[A l c h ė m y̆]

62 Clayton Street, Asheville NC 28801
828.575.9419
www.alchemyasheville.com
alchemyasheville@gmail.com

Fees

- Initial Acupuncture Treatment and Health History Consultation **$95**/Follow-up Acupuncture Treatment **$75**
- Student Rate Acupuncture Treatment **$55**
- Community-Style Acupuncture Treatment **$30-$65 Sliding Scale**
- Facial Rejuvenation Acupuncture Treatment **$150**
- Ear Acupuncture Weekly Package **$50**
- Children's Acupuncture Treatment for children under age 13 **$35**
- Herbal Consultation **$45**/Follow-up **$35**
- Nutritional Consultation **$45**/Follow-up **$35**
- Massage Therapy 60 min **$75**/ 90 Min **$105**/ 120 Min **$130**
- Herbal medicine varies in price and is a separate cost from treatments

Scheduling and Payment Policies

- Office hours are available by appointment.
- A 24 hour notice is required for cancellation or rescheduling, otherwise you will be billed for the full cost of the appointment time.
- If you are late to your appointment, that appointment will be shortened in order to complete the treatment at the scheduled time.
- Full payment is expected at time of service. We accept cash, check, and major credit cards. We are able to provide you with a receipt upon request. There is a $25 fee for returned checks.
- Alchemy is not responsible for any billing associated with your insurance. A receipt for your office visit will be provided upon request; you have the option to check with your insurance carrier to see if reimbursement is possible.

Your Arrival

We appreciate your on time arrivals for all appointments. If you arrive early, feel free to come in enjoy a cup of tea. Please silence your cell phone upon entering the building. Parking is available in our parking lot behind the building where our main entrance is located.

Preparation

When possible, we ask patients to print out the Initial Health History Forms, and fill them out before coming to your first appointment. If you are unable to print the forms, please arrive 30 minutes in advance of your scheduled appointment time to fill out the forms. Also, please remember to provide a list of any and all medications and or supplements that you are currently taking (with dosage). We recommend wearing comfortable, loose fitting clothes. We request that you eat a snack or a small meal with in two hours your scheduled treatment time.

Your treatment

Treatments take place in a peaceful, private, comfortable environment. Your visit will begin by discussing health history and your specific goals for treatment, and in addition the intake will include pulse taking and tongue observation. Upon assessing your health condition, your practitioner may select from a variety of techniques to complement your acupuncture treatment. These techniques include: massage, cupping, gua sha, moxibustion heat therapy, electro acupuncture or qi gong rehabilitation. Your treatment may also include dietary and exercise planning that will complement your acupuncture. Treatments will range from 60-90 minutes. To get the most out of your treatment, please take time to relax and reflect both during and after. Following treatment, it is best to keep work or exercise to a minimum for several hours. Our goal is to provide you with the knowledge and tools to support your healing. We encourage patient participation with any questions and feedback.

Herbal Medicine

Treatments at the clinic include herbal medicine, acupuncture, nutrition, and many other techniques Chinese herbal medicine is tailored to the needs of each patient and used to treat both acute and chronic conditions. Primary options for herbal treatments are the use of teas, tinctured liquid extracts, tea pills, and essential oils. Your practitioner may recommend herbal medicine, which the patient may choose to purchase for their treatment.

ACKNOWLEDGEMENT OF RECEIPT OF CLINIC POLICIES
I have read, understood, and agree to the office policies for healthcare services at Alchemy

_____

Print Signature Date

We greatly appreciate your support and involvement in Alchemy. We look forward to providing you with an excellent healthcare experience. Suggestions, questions and concerns may be directed to your acupuncturist or the receptionist.

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Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. All your answers will be held absolutely confidential. If you have questions, please ask. We will also discuss these questions on the first visit. Thank you for being here!

Name: _____ Date: ____/____/_____

How did you Hear about us: _____

Telephone: Home: _____Work: _____ Cell: _____

Mailing Address: _____

Email address: _____

Height_____ Weight_____ Age_____ Date of Birth: _____ Place of Birth: _____

Occupation (Current) _____(Past) _____

Single / Married / Partnered / Separated / Divorced / Widowed

Emergency Contact: _____ Relationship to you: _____ Contact #_____

Primary Care Physician: _____

How would you like to be reminded of your next appointment? phone call / email / no reminder necessary

Have you ever used Chinese medicine for your health care? _____
For what reason? _____

Prioritize your most important health concerns today?

Concern	Onset	Frequency	Severity
Ex: Headache	June 1978	4 times/wk	mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Western Medical Diagnosis (if you have one)_____

With whom do you live?

Name	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Children who don't live with you

Name	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

What do you hope for and what are your expectations from this session today?

_____
_____
_____

On a long term basis?

_____
_____
_____

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____
_____

Please list three things you would like to change about your health and well-being.

_____
_____
_____

Please list approximate dates and briefly describe any accidents, hospitalizations, surgeries, or major illnesses you have had.

_____
_____
_____
_____
_____

Please indicate areas of concern (pain, tension, numbness, tingling, swelling, etc.):

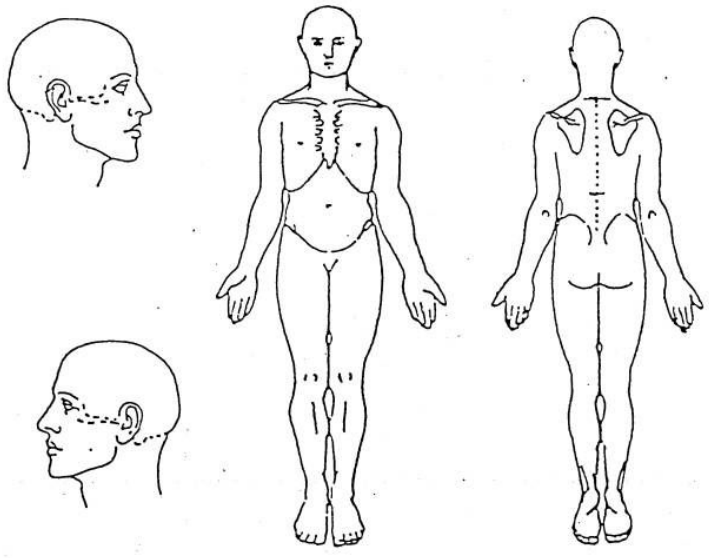
How long have you had this pain?_____
Describe the onset of your pain:_____

On a scale of 1-10 (10 worst), how strong is your pain?_____

What does your pain feel like?

_____
[ ] Dull [ ] Sharp [ ] Stabbing [ ] Sore [ ] Achy [ ] Cramping
[ ] Electrical [ ] Burning [ ] Constant [ ] Comes and goes
[ ] Fixed [ ] Moves around [ ] Other:

Does the pain radiate? Yes / No
If yes, where?_____
What helps the pain?_____
[ ] Ice [ ] Heat [ ] Rest [ ] Movement [ ] Pressure [ ] Moisture
[ ] Massage [ ] Nothing[ ] Other:



What aggravates the pain?_____
[ ] Ice [ ] Heat [ ] Rest [ ] Movement [ ] Pressure [ ] Moisture [ ] Massage [ ] Nothing [ ] Other:

What other treatments have you tried for this pain?_____

Medications, Herbs, & Supplements

Please list all medications (prescription and over-the-counter) and supplements that you are taking or have taken in the past for longer than 3 months. Please also note the reason for which each is taken.

Dosage **Reason** **How long**

_____
_____
_____
_____
_____

Diet and Lifestyle

Please list when and what you ate yesterday:

Breakfast_____ time: _____
Lunch_____ time: _____
Dinner_____ time: _____
Snacks_____ time: _____

Alcohol _____drinks per day/week Tobacco _____ per day/week Caffeine _____ per day/week

Are you recovering from any addictions? Please be specific. _____If yes, how long have you been clean? _____

Exercise (type(s)) _____ _____# times per week
TV/Video/Computer_____hours per day Do you use recreational drugs? If yes, what type?_____

How many hours per night do you sleep on average? _____ Do you wake rested? _____

How would you describe the quality of your sleep? _____

Have you experienced any major traumas? Y / N Explain: _____

Medical History

Please circle any symptoms or conditions you are experiencing either currently or have experienced in the past. Please indicate when each symptom or condition first appeared and for how long it lasted, if known.

Eyes

_____Blurred vision
_____Dryness
_____Redness, itchiness, or pain
_____Excessive tearing
_____Poor night vision
_____Spots or floaters
_____Double vision
_____Glaucoma
_____Cataracts
_____Other (describe)

Ears

_____Hearing loss
_____Ringing
_____Earache
_____Discharge or fullness
_____Other (describe)

Head and Neck

_____Dizziness or fainting
_____Vertigo
_____Headache/migraines
_____Swellings
_____Tension/stiffness
_____Other (describe)

Nose, Throat, and Mouth

_____Nasal congestion
_____Phlegm or discharge
_____Allergies
_____Sinus infection
_____Postnasal drip
_____Frequent cold/flu
_____Nosebleed
_____Dry nose
_____Dry mouth
_____Sores or swellings
_____Dental/gum problems
_____Jaw tension/tightness
_____Teeth grinding
_____Facial pain
_____Dry or sore throat
_____Strong thirst
_____Difficulty swallowing
_____Loss of voice
_____Other (describe)

Skin

_____Rashes or hives
_____Acne
_____Eczema/psoriasis
_____Itching or redness
_____Dry or oily skin
_____Abnormal sweating
_____Easy bruising
_____Lumps or swellings
_____Varicose veins
_____Other (describe)

Chest

_____Difficulty breathing
_____Frequent sighing
_____Chronic cough
_____Cough up mucous/blood
_____Tight or stuffy chest
_____Pneumonia or bronchitis
_____Palpitations
_____Rapid/irregular heartbeat
_____Chest pain
_____High or low blood pressure
_____Heart murmur
_____Heart disease
_____Other (describe)

Body and Limbs

_____Heaviness or stiffness
_____Limited range of motion
_____Numbness or tingling
_____Paralysis
_____Seizures or tremors

Sleep

_____Difficulty staying asleep
_____Disturbing dreams
_____Waking due to pain
_____Night sweats
_____Fatigue or energy drops
_____Restlessness or hyper
_____Waking to urinate
_____Other (describe)

Urinary

_____Urinary/kidney infection
_____Burning/hot urination
_____Cloudy urine
_____Strong odor
_____Blood in urine
_____Disrupted flow
_____Incomplete emptying
_____Frequent or urgent
_____Difficult urination
_____Incontinence
_____Other (describe)

Gastrointestinal

_____Low or excessive appetite
_____Bloating/flatulence
_____Abdominal heaviness
_____Nausea or vomiting
_____Belching or hiccupping
_____Heartburn or reflux
_____Sluggish digestion
_____Abdominal pain
_____Change in weight
_____Altered taste
_____Bad taste in mouth
_____Bad breath
_____Diarrhea/loose stools
_____Constipation
_____Difficult bowel movements
_____Laxative dependence
_____Blood in stool
_____Other (describe)

Urogenital (male and female)

_____Low or high libido
_____Pain or itching of genitals
_____Genital discharge or lesions
_____STD/STI
_____Other (describe)

Male

_____Impotence
_____Premature ejaculation
_____Nocturnal emissions
_____Lumps in testicles
_____Hernia
_____Enlarged prostate
_____Other (describe)

Female

(see attached form)

Hot and Cold

_____Feel hot or cold
_____Cold hands or feet
_____Desire hot or cold

Mental/Emotional

_____Poor memory
_____Foggy headedness
_____Difficulty focusing
_____Depression
_____Mood swings
_____Irritable/frustration/anger
_____Difficulty relaxing
_____Loneliness
_____Sensitivity
_____Shyness
_____Frequent crying
_____Worry
_____Anxiety
_____Compulsive behaviors
_____Suicidal thoughts
_____Eating disorder

FAMILY HEALTH HISTORY

	Age	Important Diseases/Illnesses	Deceased Y/N
Father			
Mother			
Children			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Do you have any info about your birth? _____
_____

Your mother's pregnancy?_____

Is there anything else you would like me to know? _____
_____
_____
_____

Thank you for taking the time to complete this form. We look forward to working with you!

Gynecological History

*** If menopausal please reference history of menstrual cycles ****

Age at Menarche_____
# of Live Births _____
# of Abortions_____

# of Pregnancies_____
# of Miscarriages_____

Contraceptive Type

_____
_____
_____
_____

# of Years utilized

_____
_____
_____
_____

Any side effects or negative response to contraceptive?_____

How many days is/was your last menstrual cycle? _____
How was your last menstrual cycle? Circle all that apply:

Regular	Irregular	Early	Late	Every __ months

How many days do/did you bleed? Circle:

Bleeding less than 3 days	From 3 to 5 days	Bleeding over 5 days

Quality of blood (circle all that apply):

Red / Light	Brown / Dark
Scant	Profuse

How many tampons or pads per day? _____ Clots (size)? _____

Do/Did you experience spotting?

Before period	After period	During ovulation

What type of premenstrual symptoms do/did you experience? Circle all that apply:

Pain in lower abdomen	Pain in low back	Pain radiating to genitals or legs	Cramps with downbearing sensation
Bloating	Changes in appetite	Loose stools	Constipation
Headache	Mood fluctuations	Lightheadedness	Dizziness
Cold abdomen or low back	Sleep disturbances	Sweating, night sweats	Acne

Other symptoms: _____
_____
_____

Do/Did you experience breast tenderness, breast pain, or nipple pain? _____ Any nipple discharge? _____

If so, onset and duration? _____

Any breast pain, irritability, or cramping around ovulation? _____

Do you experience abnormal vaginal discharge? _____ When (circle)? **Before** / **During** / **After** ovulation

Describe color, quantity, odor: _____

Do you experience an increase in cervical fluid around ovulation? _____

How is your libido (circle)? **Low**/ **Normal**/ **High** Does it change throughout the cycle? _____

Do you experience painful intercourse? _____

Any history of vaginal dryness, itching, or sores? _____

Any vaginal or rectal itching or history of candida overgrowth? _____

Any history of STDs/STIs? _____ Was this treated? _____

Have you ever been diagnosed with ovarian cysts, endometriosis, fibroids, or adenomyosis? _____

Have you ever had an abnormal pap smear or cervical biopsy? _____

Have you ever had any other reproductive diagnosis (approximate date)? _____

Have you ever had pelvic or gynecological surgeries (approximate date)? _____

Any hormonal evaluations or blood tests? _____ Results _____

FSH	LH	Estradiol	Progesterone
AMH	Prolactin	DHEA	Testosterone

Have you had any hormonally stimulated cycles? _____ What were the results? _____

Please include any additional information you would like to provide to us: