

# Bartlett Acupuncture & Herbal Medicine

70 Woodfin Place Suite West Wing Two 828 258-2777 Asheville, North Carolina 28801

## Integrative Health History

Name \_\_\_\_\_ Date \_\_\_\_\_ E-mail \_\_\_\_\_  
Phones: \_\_\_\_\_ (hm) \_\_\_\_\_ (wk) \_\_\_\_\_ (cell)  
Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_  
Who should we thank for referring you? \_\_\_\_\_ E-Mail \_\_\_\_\_  
Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

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What are your primary health concerns? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any secondary health concerns you may have:

\_\_\_\_\_  
\_\_\_\_\_

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Who is your current Healthcare Provider? \_\_\_\_\_

Address \_\_\_\_\_  
Phone \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

What is your:

Height \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Age \_\_\_\_\_  
Weight \_\_\_\_\_ Weight, 1 yr ago \_\_\_\_\_ Date of Birth \_\_\_\_\_

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**Personal Health History:** Check the appropriate box if you have experienced any of the following:

- |  |  |
|--|--|
| <input type="checkbox"/> Adverse reaction to medical treatment | <input type="checkbox"/> Kidney Disorder                 |
| <input type="checkbox"/> Allergies                             | <input type="checkbox"/> Low Blood Pressure              |
| <input type="checkbox"/> Anemia                                | <input type="checkbox"/> Musculo-skeletal Disorder       |
| <input type="checkbox"/> Arthritis or rheumatism               | <input type="checkbox"/> Organ Transplant                |
| <input type="checkbox"/> Artificial heart, valve or joints     | <input type="checkbox"/> Pacemaker                       |
| <input type="checkbox"/> Bleeding Disorder                     | <input type="checkbox"/> Respiratory Disorder            |
| <input type="checkbox"/> Blood Disease                         | <input type="checkbox"/> Rheumatic Fever                 |
| <input type="checkbox"/> Cancer or Tumor                       | <input type="checkbox"/> Sciatica                        |
| <input type="checkbox"/> Chemical Dependency                   | <input type="checkbox"/> Seizures/Epilepsy               |
| <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Skin Disorders                  |
| <input type="checkbox"/> Eating Disorder                       | <input type="checkbox"/> Special Diet                    |
| <input type="checkbox"/> Eye Disorder                          | <input type="checkbox"/> Stomach or Intestinal Disorder  |
| <input type="checkbox"/> Gout                                  | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Headaches                             | <input type="checkbox"/> Thyroid Disease                 |
| <input type="checkbox"/> Heart Disease                         | <input type="checkbox"/> Transfusion (before March 1985) |
| <input type="checkbox"/> Hemophilia                            | <input type="checkbox"/> Tuberculosis                    |
| <input type="checkbox"/> Hepatitis, jaundice or Liver disorder | <input type="checkbox"/> Ulcer                           |
| <input type="checkbox"/> Herpes                                | <input type="checkbox"/> Urinary Tract Disorder          |
| <input type="checkbox"/> High Blood pressure                   | <input type="checkbox"/> Venereal Disease                |
| <input type="checkbox"/> Immune Disorder                       | <input type="checkbox"/> Other: _____                    |



**Habits:** Please mark any of the habits listed below which apply to you. Mark "X" for current habits. Mark "✓" for past habits.

Use of tobacco:  Yes  No If yes, # of cigarettes/day \_\_\_\_\_ age started \_\_\_\_\_  
Use of alcohol:  Yes  No If yes, # of drinks per week \_\_\_\_\_ age started \_\_\_\_\_  
Use of Caffeine:  Yes  No # colas / day \_\_\_\_\_ # coffee / day \_\_\_\_\_ # tea / day \_\_\_\_\_

**Previous Pregnancies:** Please fill in completely.

Year	Length of Preg	Labor Hours	Type of Delivery	Sex	Weight	Name
1. _____						
Complications _____						
2. _____						
Complications _____						
3. _____						
Complications _____						

**Tell us about your lifestyle:**

What sort of diet do you have? (check one)  Standard American  Weight loss type  
 Fast/Quick Prep Diet  Vegetarian  Vegan  Low Fat  Low Carbs  
 Muscle Building Diet  Balanced Food Groups  Other \_\_\_\_\_

Please show usual foods and beverages:

Breakfast	Snack	Lunch	Snack	Dinner	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is Nutrition or Diet something you'd like to improve or be evaluated for?  Yes  No

Are you active? (check one)  Sedentary Job w/o exercise  Sedentary Job w/ Much Exercise  
 Sedentary Job w/ Some Exercise  Active Job w/o Extra Exercise  Active Job w/ Exercise

What type of exercise do you do? \_\_\_\_\_

Would you like evaluation for the best form of exercise for your body and health?  Yes  No

How would you characterize your life in terms of stress? (check one)

High Stress  Much Stress  Fairly Stressed  Mild Stress  Periodic Stress  Not Stressed  
Would you like to be handling stress better, or reduce the effects of stress?  Yes  No

Do you experience any of the following moods often? (check all that apply)

Depression  Anxiety  Insecurity  Anger  Irritability  Phobias  Nervousness  
 Mood Swings  Sadness  Short Tempered  Obsessive Thinking  Isolated  Hopelessness  
Would you like to be evaluated for possible treatment solutions for these states?  Yes  No

**Please check off symptoms you have had in the past 3 MONTHS.**

If a box indicates several symptoms, please circle the one you experience.

**Part A:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cough<br>___ acute<br>___ chronic<br>___ dry<br>___ phlegm, white, clear<br>___ phlegm, green or yellow<br>___ blood | <input type="checkbox"/> Allergies<br>___ seasonal<br>___ year round<br>___ pollen<br>___ dust<br>___ mold<br>___ pets<br>___ chemicals<br>other _____ | <input type="checkbox"/> Nasal congestion               |
| <input type="checkbox"/> Sore throat<br>___ itchy<br>___ burning  | <input type="checkbox"/> Itchy eyes  | <input type="checkbox"/> Sinus congestion               |
| <input type="checkbox"/> Hoarseness   | <input type="checkbox"/> Sneezing  | <input type="checkbox"/> Sinus pain                     |
| <input type="checkbox"/> Frequent colds/flu   | <input type="checkbox"/> Nasal discharge<br>___ white, clear<br>___ green, yellow<br>___ odor  | <input type="checkbox"/> Shortness of breath            |
| <input type="checkbox"/> Swollen glands   |  | <input type="checkbox"/> Wheezing                       |
| <input type="checkbox"/> Painful lymph nodes  |  | <input type="checkbox"/> Chest Oppression/<br>tightness |
| <input type="checkbox"/> Fever/chills   |  | <input type="checkbox"/> Grief/ sadness                 |
|   |  | <input type="checkbox"/> Crave spicy foods              |
|   |  | <input type="checkbox"/> Skin rashes, eczema,<br>hives  |
|   |  | <input type="checkbox"/> Spontaneous sweating           |

**Part B:**

**For following symptoms indicate if daily, weekly or monthly:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Nausea _____                       | <input type="checkbox"/> # of bowel movements<br>per day ____  | <input type="checkbox"/> Slow wound healing               |
| <input type="checkbox"/> Vomiting _____                     | ___ loose  | <input type="checkbox"/> Frequently fatigued              |
| <input type="checkbox"/> Bloating _____                     | ___ hard   | Time of day<br>_____                                      |
| <input type="checkbox"/> Gas _____                          | ___ painful  | <input type="checkbox"/> Organ prolapse                   |
| <input type="checkbox"/> Belching _____                     | ___ blood or mucus   | <input type="checkbox"/> Loss of taste                    |
| <input type="checkbox"/> Acid<br>regurgitation _____        | ___ difficult  | <input type="checkbox"/> Crave sweets                     |
| ___ sour  | ___ odorous  | <input type="checkbox"/> Crave carbohydrates              |
| ___ thin  | ___ burning  | <input type="checkbox"/> Heavy limbs                      |
| ___ burning   | ___ alternating diarrhea &<br>constipation                     | <input type="checkbox"/> Weak muscles                     |
| <input type="checkbox"/> Stomach pain                       | ___ hemorrhoids  | <input type="checkbox"/> Easily worried, over<br>thinking |
| <input type="checkbox"/> Ulcers                             | <input type="checkbox"/> Fatigue or discomfort<br>after eating | <input type="checkbox"/> Cloudy/ Foggy-headed             |
| <input type="checkbox"/> Bad breath                         | <input type="checkbox"/> Poor appetite                         | <input type="checkbox"/> Edema, water retention           |
| <input type="checkbox"/> Gum bleeding                       | <input type="checkbox"/> Recent weight gain                    | <input type="checkbox"/> Varicose/spider veins            |
| <input type="checkbox"/> Large appetite/Excessive<br>hunger | <input type="checkbox"/> Recent weight loss                    |   |
|   | <input type="checkbox"/> Bruises easily                        |   |

**Part C:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Irritability                             | <input type="checkbox"/> Dizziness<br>___ postural<br>___ empty headed<br>___ heavy headed | <input type="checkbox"/> Eye<br>pain/strain/sensitivity |
| <input type="checkbox"/> Frustration                              |  | <input type="checkbox"/> Neck and shoulder<br>tension   |
| <input type="checkbox"/> Easily stressed/tense                    | <input type="checkbox"/> Vertigo   | <input type="checkbox"/> Tremors                        |
| <input type="checkbox"/> Easily angered<br>___ frequent outbursts | <input type="checkbox"/> Dry hair, skin, nails   | <input type="checkbox"/> Numbness                       |
| <input type="checkbox"/> Rib side pain                            | <input type="checkbox"/> Dry eyes, floaters,<br>blurred vision                             | <input type="checkbox"/> Hiccups                        |
| <input type="checkbox"/> Frequent sighing                         | <input type="checkbox"/> Red eyes  | <input type="checkbox"/> Bitter taste in mouth          |
| <input type="checkbox"/> Sensation of something<br>in throat      |  | <input type="checkbox"/> Clearing throat often          |

**FOR WOMEN:**

First day of last period \_\_\_\_\_

# of days in menstrual cycle \_\_\_\_\_

# of days of bleeding \_\_\_\_\_

# of pads/tampons per day \_\_\_\_\_

Color of blood: \_\_ pale\_\_ purple

\_\_ bright red \_\_ dark red

\_\_ brown

- Clots
  - \_\_ red
  - \_\_ purple
  - \_\_ small (cottage cheese)
  - \_\_ large

- Cramping
  - \_\_ before
  - \_\_ during
  - \_\_ end
- PMS symptoms
  - \_\_ mood changes
  - \_\_ breast tenderness/swelling
  - \_\_ food cravings
  - \_\_ headaches
- Bleeding in between periods
- Fibroids
- Breast lumps/fibrocystic
- Hot flashes
- # of pregnancies \_\_\_\_\_
- # of live births \_\_\_\_\_

Type of birth control \_\_\_\_\_

- Pregnant
- Nursing
- Abnormal pap test
- History of vaginal warts
- Vaginal pain
  - \_\_ with sexual intercourse
- Vaginal discharge
- Infertility
- GYN surgeries (date/type) \_\_\_\_\_
- Regular breast exam \_\_\_\_\_

**Part D:**

- Low back, knee pain
- Poor hearing/hearing aid
  - # of years \_\_\_\_\_
- Ear ringing
- Hair loss
- Premature graying
- Cold hands & feet
- Generalized cold feeling
- Warm body temperature
- Frequent urination
- Scanty urination
- Night urination
- Urgent urination
- Profuse urination
- Color of urination
  - \_\_ Dark \_\_ Straw
  - \_\_ Light/clear\_\_ Cloudy
  - \_\_ Bloody\_\_ Painful
- Hesitant urination/dribbling
- Sex drive/libido
  - \_\_ Low \_\_ High
- Puffy beneath eyes
- Dark circles under eyes
- Fear/ phobias/ inventing worst case scenarios
- Lack of will/drive/motivation
- Crave salt
- Swollen ankles
- Birth disorders/defects
- Childhood developmental problems
- Osteoporosis
- Poor teeth

**FOR MEN:**

Last prostate exam \_\_\_\_\_

PSA results \_\_\_\_\_

- Prostatitis/BPH
- Infertility
  - \_\_ Low sperm count
  - \_\_ Poor sperm mobility
- Erectile Dysfunction (ED)
  - \_\_ Low sperm progression
  - \_\_ Difficulty achieving erection
- Difficulty maintaining erection
- Premature ejaculation

**Part E:**

- Palpitations
- Difficulty falling asleep
- Wake during night
- Restless
- Night sweating
- Thirst
- Dry mouth/throat
- Mouth sores/sore tongue
- Poor memory
- Jittery, easily startled
- Anxiety
  - \_\_ Racing thoughts
  - \_\_ Overwhelm
- Depression

## Headache:

Location:

- top
- temples
- forehead
- back of head

How long? \_\_\_\_\_

Time of day: \_\_\_\_\_

Type of pain:

- dull
- sharp/stabbing
- distended/throbbing
- heavy headed
- band like

Visual Problems:

- see lights
- see auras

- Dislike light
- Dislike noise
- Worse with stress
- Worse with fatigue
- Empty-headed
- Dizziness
- Nausea/Vomiting

## BODY PAIN:

Date began: \_\_\_\_\_

Cause: \_\_\_\_\_

Describe location: \_\_\_\_\_

\_\_\_\_\_

Type of Pain:

- dull/achy
- sharp/stabbing
- burning
- constant
- intermittent
- How often? \_\_\_\_\_
- Time of day \_\_\_\_\_
- radiating
- fixed
- moves around
- severe
- moderate
- mild discomfort

What makes it better?

- Cold
- Heat/hot shower
- Pressure/massage
- Activity/movement
- Rest

What makes it worse?

- Cold
- Cold/damp weather
- Rest
- Activity/movement
- Pressure/massage

- Numbness (no feeling)
- Pins and needles

Diagnostic Tests:

(List date/findings)

X-Ray \_\_\_\_\_

MRI \_\_\_\_\_

CAT \_\_\_\_\_

Surgeries (date/type):

\_\_\_\_\_

\_\_\_\_\_



## *Bartlett Acupuncture & Herbal Medicine*

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[www.BartlettAcupuncture.com](http://www.BartlettAcupuncture.com)

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### **INFORMED CONSENT FOR TRADITIONAL CHINESE MEDICAL TREATMENT**

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of Traditional Chinese Medicine (TCM) on me (or on the patient named below, for whom I am legally responsible) by Kath Bartlett, MS, LAc, or any other licensed acupuncturist who now or in the future may treat me while associated with or serving as back-up to Kath Bartlett, including those working at Asheville Center for Chinese Medicine or at any other office or clinic, whether signatories to this form or not.

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

Acupuncture's effects include: normalizing physiological function, decreasing pain and treating diseases and dysfunctions of the body. I have been informed that acupuncture is a safe procedure. Occasionally, bruising or tingling or numbness may occur near the needle site which can last up to a few days following acupuncture treatment. Bruising may occur after cupping procedure. On rare occasion, a patient may experience dizziness or fainting during or immediately after acupuncture treatment. Eating within two hours prior to acupuncture treatment will generally prevent occurrence of these symptoms. There have been rare reports of infections and burns (associated with cupping or moxibustion). There have been extremely rarely reported and unusual incidences of spontaneous miscarriage, nerve damage and pneumothorax. Asheville Center for Chinese Medicine uses sterile, disposable needles and maintains a clean and safe clinic environment. Kath Bartlett, MS, LAc is a highly trained and skilled practitioner, certified in Clean Needle Technique by CCAOM. Other than occasional and minor bruising, it is highly unlikely that any of the aforementioned, negative side effects will occur.

Positive side effects to be expected from acupuncture treatment include deep relaxation and sensation of well being, increased energy, decreased feelings of stress, decreased incidences of illness, and improved physiological and mental function of the body, mind and spirit.

Chinese herbal formulas, including plant, mineral and animal sources, are considered safe in the practice of Oriental medicine. Some of the herbs are inappropriate during pregnancy and a few of the herbs are considered toxic when taken in high dosages. Kath Bartlett, MS, LAc is a competent and experienced herbalist, Board Certified in Chinese Herbology and Oriental Medicine by NCCAOM. She is knowledgeable in safe dosing ranges, cautions and contraindications of Chinese herbs.

I understand the herbs may need to be prepared and the teas consumed according to the written and oral instructions provided. The herbs may have an unpleasant smell or taste. Occasional side effects caused by herbs are generally limited to gastro-intestinal symptoms, such as gas, bloating, stomachache, or changes in bowels. More rarely, headache or nausea may occur. On extremely rare occasion, a patient may experience a rash or hives, vomiting, or tingling of the tongue. Any adverse symptoms caused by herbs will stop when the herbs use is discontinued. Any symptoms persisting after cessation of Chinese herbal therapy were not caused by the herbal formula. If I experience any gastro-intestinal symptoms, allergic reactions or any other unanticipated or unpleasant effects associated with the consumption of the herbs, I will immediately inform the herbalist. Generally, the herbal prescription can be modified to prevent any adverse symptoms from continuing.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I will rely on the acupuncturist to exercise professional judgment during the course of treatment, and to act in my best interest based on the available facts then known. If I become pregnant, I will notify the acupuncturist immediately.

I have read (or have had read to me) the above consent for Traditional Chinese Medical treatment, and my questions have been answered regarding its content. By signing below I agree to receive the above named procedures, and any other techniques comprising Oriental Medicine. I understand that results are not guaranteed. I intend this consent form to cover the entire course of treatment for my present condition, and any future condition for which I may seek treatment.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient's Signature (or representative of patient)

\_\_\_\_\_  
Office Signature

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Date



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### CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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#### SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of you protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you DECIDE whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of privacy practices, including any revisions of our Notice, at any time by contacting:

Kath Bartlett  
70 Woodfin Place Suite West Wing Two  
Asheville, NC 28801  
828-258-2777

**RIGHT TO REVOKE:** You will have the right to revoke this Consent at any time by giving us written notice of you revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, \_\_\_\_\_, have been informed of, and given the right to review and received a copy of your *Notice of Privacy Practices*. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**



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## FEE SCHEDULE

Initial Consultation - No treatment (1 – 1 ¼ hours)	\$90.00
Acupuncture Treatment (1 ¼ - 1 ½ hours)	\$72.00
Herbal Consultation	\$60.00
Phone Consultation (Less than thirty minutes)	\$45.00
Quick updates & brief discussions of treatment or herbal progress.	
Clinical Consultations	\$70/hour \$40/half hour
(Extended consultations to discuss treatment progress, emotional or lifestyle factors affecting your condition, & dietary/nutritional consultations.)	
Herbs (Raw and Granules)	\$25 - \$40/week
Raw and granulated herbs are individually formulated for each patient. They are not hermetically sealed, therefore cannot be given to another patient, and so are <b>not returnable</b> .	
<b>Third</b> Treatment in the <b>Same Week</b> Discount	-\$30.00
If you have 3 treatments in the <b>same week</b> , a \$30 discount is given on the <b>Third</b> treatment (-\$10/per treatment)	
Cancellation & Missed Visit Fee	\$45.00
Less than one business day's notice given. (Courtesy reminder calls are made the day before the scheduled appointment.)	

### SCHEDULING ACUPUNCTURE APPOINTMENTS:

You may schedule acupuncture treatments before other appointments on the same day, such as doctors, dentists, chiropractors, PT, massage therapists, attorneys, hair salons, etc, but please **Do Not schedule acupuncture appointments after other appointments.**

### CANCELLATION POLICY

**Notification** of cancellation or re-scheduling must be received **By Telephone** on **Weekdays (Monday through Friday)** between the hours of **10:30am and 6pm**. Acupuncture visits are generally scheduled a week or more in advance. **As a courtesy, please give as much notice as is possible prior to cancel or re-schedule visits** so that appointment times will be available for scheduling other patients.

**If you do not give a full business day's notice of the appointment time change a \$45.00 cancelation fee will be charged to your account.** If a new, acute condition or illness arises, please keep your previously scheduled acupuncture appointment. The new condition will be treated with Chinese medicine.



## **SHOULD I KEEP MY APPOINTMENT IF I'M SICK?**

Every so often a patient will call to cancel an acupuncture appointment because "I'm sick". This reasoning perplexes acupuncturists, because if you're sick, why not keep your appointment so that your practitioner can treat the acute illness? It makes us realize that patients don't really see us as doctors. But we are, (Chinese) doctors! Most acupuncturists are GP's: General Practitioners. That means that rather than specializing in a particular clinical discipline, such as gynecology, dermatology, infertility, pain management, etc., acupuncturists treat whatever comes through the door. On any given day, we might treat gyn issues, such as PMS, cramping or perimenopausal complaints, followed by digestive problems like acid regurgitation or bowel irregularities next might come headache followed by back, neck or joint pain. We see skin rashes: hives, eczema and herpes, lung conditions including sinusitis, allergies, bronchitis and the common cold and flu, in addition to more complex medical problems.

Acupuncture and Chinese herbs are highly effective for treating acute conditions, such as colds and flu, stomach viruses and headaches. Patients report immediate improvement in symptoms after acupuncture treatment and herbal therapy. Happy patients frequently say, "As soon as I started taking the herbs I felt better!"

Many patients call immediately to schedule a treatment when they first notice cold or flu symptoms. These include healthcare practitioners who don't want to get their patients sick, business professionals who are too busy for a sick day or two, and patients who are chronically ill and want to 'get this one over with, quickly'.

So if you're sick, call your acupuncturist and make an appointment. If you have an appointment scheduled, keep it. If you're concerned about being contagious to your practitioner, request an herbal consultation instead of an acupuncture treatment.

## **ACUPUNCTURE TREATMENT GUIDELINES**

### **What should I wear for acupuncture treatments?**

Wear loose fitted, comfortable clothing. You might want to bring a tank top and shorts to allow the acupuncturist easy access to the body. Most of the points needled are on the torso and limbs, below the elbows and knees. Exceptions are for pain, where local points will be used in the affected area, such as the shoulder.

### **Other Reminders:**

Remember to eat before your treatment. You should have a meal 1-3 hours prior to the treatment. If you are not able to eat a full meal, then be sure to have a lite snack (muffin, hard boiled egg) ½-1 hour prior to your treatment. It is best not to have sex the day of the treatment. At minimum allow a 4-5 hour interval. Work out prior to your treatment, or wait several hours before engaging in heavy exercise. It is recommended to do other therapies (chiropractor, massage, PT) prior to your treatment.



## HOW TO SPEAK EFFECTIVELY WITH YOUR DOCTOR

Visiting a healthcare practitioner (western medical doctor, acupuncturist, chiropractor, physician's assistant, physical therapist, nurse practitioner) requires good communication skills on behalf of both patients and doctors. Patients need to be able to convey medical information in a clear and concise manner. Practitioners must be able to tell patients in plain English what is causing their symptoms and what must be done to treat the condition effectively. During the discourse, key information often does not get relayed, for a variety of reasons. What can you do to communicate more effectively with your doctor?

- 1) Treat your doctor visit as a business meeting. You have a short amount of professional time to relay much key information about your condition. Manage the time wisely.
- 2) It's your responsibility to communicate key information in an orderly fashion: such as medical background and symptomatic progression of medical events. If you have a number of health concerns to discuss, prepare in advance for the meeting with your doctor. Organize your thoughts and perhaps take notes about key symptoms so that you can convey the information as clearly and succinctly.
- 3) Keep to the symptoms and refrain from anecdotal stories. It's easy to go off on a tangent about your visit to your aunt's when you noticed the ache in your back. These stories waste precious professional time that should be spent discussing your symptoms and treating your disease. Did you really make an appointment with your doctor to talk about your vacation?
- 4) Be able to answer detailed questions clearly. Be specific and avoid vagaries when describing your symptoms. If the practitioner asks you about something you haven't paid much attention to; rather than providing a list of information unrelated to the question, just say 'I'm not sure', or 'I don't have an answer for that'. Make a mental note to observe your body between visits so you can provide more complete information on a subsequent visit.
- 5) If you have a number of symptoms that you are managing, keep a log of frequency, severity, time and duration, location and any other characteristics your practitioner typically asks about. It's often difficult to recall this information when the doctor asks, so write it down in advance and even hand your practitioner a copy.
- 6) If you are on many medications, keep a log of the drugs, dosages and times taken so that you can hand a copy to your medical practitioner. Especially in the western medical community, where you see a different specialist for separate conditions, the doctors are often not aware that a patient is on many other drugs in addition to what s/he is prescribing. This leads to over prescribing and drug interactions. It is vital that all of your healthcare practitioners are aware of your drug use and history.
- 7) Be honest. Don't lie or withhold information. Don't exaggerate or play down symptoms. Giving inaccurate information will only lead to misdiagnosis and treatment.
- 8) Don't be embarrassed to talk about your bodily functions. Remember, to your practitioner these are very routine conversations: discussing urine and bowel habits are no different than talking about a blown carburetor.
- 9) Don't interrupt your doctor's thought process during pauses or while taking notes. S/he is reviewing your case, looking for any holes in the medical history that require further illumination, and mentally arriving at diagnostic and treatment options for you. Use this time to do a self-review of your own. Have you communicated all that you came into say? Was there anything you omitted or feel you should convey differently?
- 10) When your doctor goes over diagnostic and treatment options for you, be sure you understand what is being said. In the medical community there is a tendency to speak in jargon. Don't be intimidated by words you don't understand. Ask for an explanation of terminology. You may find it helpful to bring a friend to help listen to diagnostic explanations and ask questions for you. Alternatively, take notes or record the conversation.
- 11) Don't interrupt your practitioner during explanations: often your questions will be anticipated and answered. Your practitioner may forget where s/he left off and this may prevent necessary information from being provided to you.
- 12) It is vital that you understand your treatment and care. Know what the drugs, herbs or nutritional supplements that are being prescribed are doing. Ask for a timeline so you know what to expect and when in terms of recovery and when therapy should be discontinued.
- 13) Be sure your practitioner has fully disclosed all possible risks and side-effects of treatment, and know what to be alerted for should treatment go array. This is especially important for drug therapy and recommended surgeries.
- 14) Organize your questions before your visit. Your doctor has to work within the timeframe of the clinic schedule. Don't corner your practitioner after the visit has concluded with questions you forgot to ask during your appointment. This will delay other patients who are waiting. The time will have to be made up by shortening another patient's treatment.

Your doctor visit is a professional appointment. Treat it as such. Arrive promptly and be prepared for your visit. By following these guidelines you will get the most efficient and effective care possible from your healthcare professional.