

Piper Dunlap, L.Ac.  
1118 Lawrence Street  
Port Townsend, WA 98368  
Phone (360) 385-3882  
Email: Piper@PiperDunlap.com

Today's Date \_\_\_\_\_

### Payment Information

<i>Fees for Services:</i>	Regular	Pay-at-time of service	
	<u>Rates</u>	<u>Rates</u>	
Initial acupuncture visit	\$125.00	\$100.00	(90 minutes)
Follow-up acupuncture visit	\$95.00	\$80.00	(60 minutes)
Initial herbal consultation	\$95.00	\$80.00	(60 minutes)
Follow up consultations (In person or phone)	\$22.00	\$20.00	(15 minutes, \$1.00 each additional minute)

#### *Forms of Payment Accepted:*

Cash, Check or Insurance are accepted. Payment in full for herbs and services rendered, including insurance co-pay, is due at the time of service.

#### *Insurance Policies currently being accepted:*

Premera Blue Cross	Regence Blue Shield
Lifewise Health Plan of Washington	First Choice Health PPO Network

If your plan is not on this list, please ask, and we will provide a superbill for you to submit to your insurance provider.

#### *Preferred method of Payment:*

- Cash or check (a \$30.00 service fee will be charged for all returned checks)
- Insurance

**If you would like us to bill your insurance, please fill out the form on the other side.**

#### *Payment Disclaimer:*

I agree to pay for all herbs and services rendered at the time of service. In the event that insurance does not pay a claim within 180 days, or does not cover a service, I understand that I am personally responsible for all charges. I agree to the release of any medical and billing information necessary to process payment. I assign medical benefits payable directly to Piper Dunlap, L.Ac.

**I understand that if I cancel an appointment with less than 24 hours notice or fail to show up for an appointment, a \$50 fee will be charged directly to me. I understand insurance will not pay for a missed appointment fee.**

\_\_\_\_\_  
Signature of patient (or guardian if patient is a minor)

\_\_\_\_\_  
Date

## Insurance Information

Full name: \_\_\_\_\_

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

Name of insured: \_\_\_\_\_  
*(If other than you)*

Insured's date of birth: \_\_\_\_\_

Address of insured: \_\_\_\_\_  
*(If different from address on page 3)*

Relationship to insured: \_\_\_\_\_

\_\_\_\_\_

Insurance plan: \_\_\_\_\_

Ins. ID#: \_\_\_\_\_

Claims phone number: \_\_\_\_\_  
*(Should be on the back of your card)*

Group #: \_\_\_\_\_

*For office use only*

Eligibility Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Patient Information

### Please Print!

Name: \_\_\_\_\_ Sex: M F Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to receive a quarterly newsletter? \_\_\_\_\_

Occupation: \_\_\_\_\_ Emergency contact: \_\_\_\_\_

Parent's name if under 18: \_\_\_\_\_ Emergency contact phone #: \_\_\_\_\_

How did you hear about Piper's practice? \_\_\_\_\_

Name of your primary health care provider:

\_\_\_\_\_

Have your complaints previously been given a particular medical diagnosis? If so, please explain.

\_\_\_\_\_

\_\_\_\_\_

Are you currently taking any prescribed medications, vitamins, supplements, and/or herbs? Please list.

\_\_\_\_\_

\_\_\_\_\_

**Present Complaint:** Symptoms, when and how problem started, anything that makes your symptoms worse or better, etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please tell me about any previous treatments you have tried for your condition (acupuncture, homeopathy, massage, nutrition, M.D., etc.) and the results.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please check any of the following that apply to you:**

DIABETES \_\_\_\_\_ HEPATITIS a, b, c \_\_\_\_\_ HYPERTENSION \_\_\_\_\_ PREGNANCY \_\_\_\_\_ TB \_\_\_\_\_  
CHEMO/RAD \_\_\_\_\_ SEIZURES \_\_\_\_\_ HEMOPHILIA \_\_\_\_\_ PACEMAKER \_\_\_\_\_ HIV/AIDS \_\_\_\_\_

**Describe your...**

General energy level: \_\_\_\_\_

Time of day you feel best and worst: \_\_\_\_\_

**What is your history for major...**

Illnesses: \_\_\_\_\_

\_\_\_\_\_

Surgeries: \_\_\_\_\_

\_\_\_\_\_

Childhood illnesses: \_\_\_\_\_

\_\_\_\_\_

**Daily habits (how much of the following substances do you consume daily?)**

Cigarettes/tobacco: \_\_\_\_\_

Alcohol (in what form): \_\_\_\_\_

Coffee/tea/caffeinated beverages: \_\_\_\_\_

Sugar: \_\_\_\_\_

Dairy products (milk, cheese, etc.): \_\_\_\_\_

Meats/fish/poultry/eggs: \_\_\_\_\_

Bread & grains: \_\_\_\_\_

Cooked vegetables: \_\_\_\_\_

Raw fruit/vegetables: \_\_\_\_\_

Specific food/flavor cravings: \_\_\_\_\_

Describe the exercise you get on a regular basis: \_\_\_\_\_

\_\_\_\_\_

***Which of these environments affect you adversely? (please circle)***

cold heat damp dry windy humidity foggy

***Which of these environments make you feel better? (please circle)***

cold heat damp dry windy humidity foggy

Do you have an intolerance to hot or cold (food, drink, or areas of the body that are hot or cold)?

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Please provide me with your family's brief medical history. Include any incidence of tuberculosis, cancer, skin disease, hypertension, nervous disorders, diabetes, arthritis, heart disease, stroke, seizures, asthma, allergies, alcoholism/substance abuse, etc.

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

Grandparents: \_\_\_\_\_

***WOMEN***

Age when periods began: \_\_\_\_\_ Last PAP: \_\_\_\_\_ Results: \_\_\_\_\_

Length of cycle: \_\_\_\_\_ days Duration of flow: \_\_\_\_\_ days Is your cycle regular? \_\_\_\_\_

Any spotting? \_\_\_\_\_ Pain? \_\_\_\_\_ PMS? \_\_\_\_\_ Vaginal discharge? \_\_\_\_\_

Difficulties during teens (pain, flow, regularity, cramps, etc.): \_\_\_\_\_

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Birth control history (method & duration of use): \_\_\_\_\_

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Obstetric history (pregnancies, births, abortions, miscarriages, etc.): \_\_\_\_\_

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Menopause: \_\_\_\_\_

STD's (herpes, warts, etc.): \_\_\_\_\_

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***MEN***

History of impotence, premature ejaculation, fertility difficulties, discharge from penis, vasectomy, etc.

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STD's (herpes, warts, etc.): \_\_\_\_\_

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Please mark present conditions with a ✓ and significant past conditions with an ✕.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Abdominal Pain                      | <input type="checkbox"/> Dry skin                         | <input type="checkbox"/> Nasal congestion                    |
| <input type="checkbox"/> Ache in low back and/or knees       | <input type="checkbox"/> Dry stools                       | <input type="checkbox"/> Nausea                              |
| <input type="checkbox"/> Acid regurgitation                  | <input type="checkbox"/> Dull and dry hair                | <input type="checkbox"/> Neck pain                           |
| <input type="checkbox"/> Allergies                           | <input type="checkbox"/> Easily frightened                | <input type="checkbox"/> Night sweats                        |
| <input type="checkbox"/> Alternating chills/fever            |   | <input type="checkbox"/> No thirst                           |
| <input type="checkbox"/> Always cold                         | <b>Emotions:</b>  | <input type="checkbox"/> Nocturnal emission                  |
| <input type="checkbox"/> Always hungry                       | <input type="checkbox"/> Anxiety                          | <input type="checkbox"/> Numbness                            |
| <input type="checkbox"/> Awaken to urinate _____ times/night | <input type="checkbox"/> Irritability                     | <input type="checkbox"/> Organ prolapse                      |
| time: _____  | <input type="checkbox"/> Grief/sadness                    | <input type="checkbox"/> Pale face                           |
| <input type="checkbox"/> Back pain                           | <input type="checkbox"/> Feelings of fear                 | <input type="checkbox"/> Palpitations                        |
| where? _____   | <input type="checkbox"/> Mania                            | <input type="checkbox"/> Paralysis                           |
| <input type="checkbox"/> Bad breath                          |   | <input type="checkbox"/> Pneumonia                           |
| <input type="checkbox"/> Bearing down sensation              | <input type="checkbox"/> Emotional prior to period        | <input type="checkbox"/> Poor memory                         |
| in groin/scrotum   | <input type="checkbox"/> Excessive dreaming               | <input type="checkbox"/> Poor vision                         |
| <input type="checkbox"/> Belching, hiccups                   | <input type="checkbox"/> Fatigue easily                   | <input type="checkbox"/> Premature ejaculation               |
| <input type="checkbox"/> Bladder/kidney stones               | <input type="checkbox"/> Feverish                         | <input type="checkbox"/> Premature gray                      |
| <input type="checkbox"/> Bleeding                            | <input type="checkbox"/> Flushed cheeks                   | <input type="checkbox"/> Red face                            |
| where? _____   | <input type="checkbox"/> Forgetfulness                    | <input type="checkbox"/> Red, painful eyes                   |
| <input type="checkbox"/> Bruise easily                       | <input type="checkbox"/> Frequent colds                   | <input type="checkbox"/> Red, painful skin eruption          |
| <input type="checkbox"/> Bloating of the stomach/abdomen     | <input type="checkbox"/> Frequent urination               | <input type="checkbox"/> Rib or side pain                    |
| <input type="checkbox"/> Blood clots                         | <input type="checkbox"/> Hair loss                        | <input type="checkbox"/> Right trunk pain                    |
| <input type="checkbox"/> Bloody urine                        | <input type="checkbox"/> Hard to project voice            | <input type="checkbox"/> Seizures                            |
| <input type="checkbox"/> Blurry vision/floaters              | <input type="checkbox"/> Headache                         | <input type="checkbox"/> Sensation of object stuck in throat |
| <input type="checkbox"/> Brittle nails                       | <input type="checkbox"/> Heaviness                        | <input type="checkbox"/> Shortness of breath                 |
| <input type="checkbox"/> Bronchitis                          | <input type="checkbox"/> Heavy menses                     | <input type="checkbox"/> Sighing                             |
| <input type="checkbox"/> Burning sensation in anus/rectum    | <input type="checkbox"/> Hemorrhoids                      | <input type="checkbox"/> Skin problems: _____                |
| <input type="checkbox"/> Burning urination                   | <input type="checkbox"/> High-pitched ringing in the ears | <input type="checkbox"/> Sleep a lot                         |
| <input type="checkbox"/> Chest/arm pain                      | <input type="checkbox"/> Hoarse voice                     | <input type="checkbox"/> Sneezing                            |
| <input type="checkbox"/> Chest fullness                      | <input type="checkbox"/> Hot palms of hands/soles of feet | <input type="checkbox"/> Sore throat or mouth                |
| <input type="checkbox"/> Chills and fever                    | <input type="checkbox"/> Hysteria                         | <input type="checkbox"/> Spasms or tremors                   |
| <input type="checkbox"/> Clearing the throat often           | <input type="checkbox"/> Impotence                        | <input type="checkbox"/> Stiffness                           |
| <input type="checkbox"/> Cloudy urine                        | <input type="checkbox"/> Incontinence of urine            | <input type="checkbox"/> Stomach pain                        |
| <input type="checkbox"/> Cold body and limbs                 | <input type="checkbox"/> Indecisiveness                   | <input type="checkbox"/> Stomach ulcer                       |
| <input type="checkbox"/> Constipation                        | <input type="checkbox"/> Indigestion                      | <input type="checkbox"/> Stroke                              |
| <input type="checkbox"/> Convulsions                         | <input type="checkbox"/> Infertility                      | <input type="checkbox"/> Sweat easily                        |
| <input type="checkbox"/> Cough or asthma                     | <input type="checkbox"/> Insomnia                         | <input type="checkbox"/> Swollen painful gums                |
| <input type="checkbox"/> Coughing up mucus                   | <input type="checkbox"/> Intermittent dull pain           | <input type="checkbox"/> Symptoms relieved by heat           |
| color: _____   | <input type="checkbox"/> Irregular heartbeat              | <input type="checkbox"/> Thirsty                             |
| <input type="checkbox"/> Dark scanty urine                   | <input type="checkbox"/> Joint pain                       | <input type="checkbox"/> Tired all the time                  |
| <input type="checkbox"/> Deafness/low-pitched                | where? _____  | <input type="checkbox"/> Tongue sores/ulcers                 |
| <input type="checkbox"/> Decreased/poor appetite             | <input type="checkbox"/> Other joint/bone problem? _____  | <input type="checkbox"/> Tooth loss                          |
| <input type="checkbox"/> Depression                          | <input type="checkbox"/> Large red spots under skin       | <input type="checkbox"/> Urgent urination                    |
| <input type="checkbox"/> Descending or sinking               | <input type="checkbox"/> Localized sharp pain             | <input type="checkbox"/> Vertigo                             |
| sensation in abdomen   | where? _____  | <input type="checkbox"/> Vomiting                            |
| <input type="checkbox"/> Diarrhea – chronic or acute         | <input type="checkbox"/> Loose stools                     | <input type="checkbox"/> Vomiting bitter fluids              |
| (please circle)  | <input type="checkbox"/> Low sex drive                    | <input type="checkbox"/> Waking between 3-5 a.m.             |
| <input type="checkbox"/> Dislike of wind                     | <input type="checkbox"/> Lumps, mass or tumors            | <input type="checkbox"/> Water retention                     |
| <input type="checkbox"/> Dizziness                           | <input type="checkbox"/> Memory loss                      | <input type="checkbox"/> Weight gain                         |
| <input type="checkbox"/> Dry eyes and nose                   | <input type="checkbox"/> Migraine headaches               | <input type="checkbox"/> Wheezing                            |
| <input type="checkbox"/> Dry mouth and throat                | <input type="checkbox"/> Muscle pain                      | <input type="checkbox"/> Yellowing of skin                   |