LISA TONGEL, LICENSED ACUPUNCTURIST
www.lisatongel.com
lisa@lisatongel.com
503 577-3669

WELCOME!

Here are a few things I'd like you to know before your first appointment.
Please contact me if you have any questions about this information.

Location:
My office is at Anisha Center for Holistic Health at **4031 SE Hawthorne Blvd. Portland, OR 97214**, at SE 41st and Hawthorne across for New Seasons Market. Parking is available on the street within a block from Anisha. Call me at 503 577-3669 if you need help finding the clinic.

Preparation:
Please wear or bring loose fitting, comfortable clothes to your appointments. I generally do not have you disrobe during your sessions, so I will need to raise your clothing above your knees and elbows. Jeans, especially "skinny jeans," or complex outfits don't work so well for this. Try yoga pants or sweat pants and a comfortable top.

Your first appointment will last 1.5 to 2 hours, and the follow-up appointments last about 1 hour . As acupuncture creates a state of peaceful relaxation, it is best not to have to rush anywhere after your sessions, and you should wait a few hours after having acupuncture to exercise strenuously.

Please be sure to have eaten something within a few hours before your appointment. Having something in your stomach will prevent dizziness or nausea during and after your sessions. However, coming right after a large meal will feel uncomfortable. A light meal or snack an hour or two before your appointment is best.

Financial Policies:
My current session fees are: $140 for new patients, $95 for return patients, and $240 for IVF day-of-embryo-transfer treatments. I request payment at the time of each appointment with cash, check, or credit card. There will be a $30 fee for all returned checks.

I currently do not bill any type of insurance directly, and I am not on any insurance panels. Upon your request, I will provide you with a superbill receipt that you may to submit to your insurance for reimbursement. Insurance reimbursement is not guaranteed, and is subject to the terms of your policy. Please contact your insurance provider to confirm your benefits.

Please note that your appointment times are reserved especially for you, and that 24 hours' notice is required for any cancellations or changes. All missed appointments or late cancellations will be subject to the full session fee.

Please sign below to acknowledge my financial and cancellation policies:

Signature_____ Printed Name_____

Date_____

Thank you. I look forward to working with you!

PATIENT INFORMATION

Name_____ Date_____

Address_____
_____

Phone (H) _____ (W)_____ (Cell)_____

Is it ok to leave a message? Y/N If yes, which number? _____

Email_____

Occupation_____ Hours per week _____

Gender: Female Male

Date of Birth _____ Age_____

Primary Care Physician's name_____

OB/GYN's name_____

Have you had acupuncture treatments before? If so, when and for what reason?_____

_____

Who referred you, or how did you hear about Lisa Tongel, L.Ac.?
_____
_____

Person to reach in case of emergency _____

Address _____

Phone _____

Relationship _____

CONFIDENTIAL HEALTH HISTORY

NAME_____ **DATE**_____

Main Areas of Concern (please include symptoms, diagnosis, duration, etc.)
1._____
2._____
3._____

Accidents/Trauma (please include physical, i.e. car accidents, falls, illnesses, as well as emotional)

_____

_____

Birth History – your own and/or your child(ren)'s (prolonged labor, forceps delivery, complications, etc.)

_____

_____

Surgeries/Hospitalizations (please include dates)_____

_____

_____

Allergies (chemical, environmental, food, drugs, etc.)_____

_____

Medications (names & dosages) Please attach an additional page if necessary.

_____

_____

_____

Vitamins/Supplements/Herbs_____

_____

_____

Exercise

Days per week Length of workout Type of Activity

Typical Diet

Meals per day # of Snacks Caffeinated Drinks Alcohol per week

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
What foods do you crave?_____ What foods do you avoid?_____
Water intake per day _____

Name_____ **Date**_____

What makes your condition better? (rest, movement, heat, cold, fresh air, eating, crying, etc.)

_____

_____

What makes your condition worse? (stress, fatigue, hunger, heat, cold, certain foods, damp days etc.)

_____

_____

Personal History

Please **circle** any conditions you have now. Please mark '**P**' next to any condition you have had in the past**.**

Arthritis	**Liver/Gall Bladder Disease**	**Stroke**	**Heart Disease**
Heart attack	**Hypo/Hyperglycemia**	**Kidney Disease/stones**	**Elevated Blood Cholesterol**
Cancer	**Diabetes**	**Impotence**	**Diverticulitis**
Ulcer	**Autoimmune Disorder**	**Hepatitis**	**Raynaud's Disease**
Chronic Fatigue	**Anemia**	**Thyroid Imbalance**	**Blood clotting disorder**
Alcoholism	**Eating Disorder**	**Chronic Pain Condition**	**HIV+**
Gastritis/Pancreatitis	**Epilepsy/Seizures**	**Prolapsed Organ**	**Emphysema**

Do/did you smoke? For how long?_____ **How many packs per day?**_____

Pacemaker **Fainting** **Other serious health condition**_____

Family Medical History

Please check any condition that applies to your family members. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to items.

Diabetes ___	**Seizures ___**	**Heart Disease ___**	**Stroke ___**
High Blood Pressure ___	**Allergies ___**	**Cancer ___ Asthma ___**	
Infertility ___	**Other**_____		

Please **circle** any symptom or condition you currently have. Please mark '**P**' next to any you've had in the past.

General

Poor Appetite	**Poor Sleeping**	**Fatigue**	**Fevers**
Chills	**Night Sweats**	**Sweat easily**	**Tremors**
Cravings	**Localized Weakness**	**Poor Balance**	**Change in appetite**
Bleed/Bruise easily	**Weight loss? Gain?**	**Peculiar tastes in mouth**	**Dental/gum problems**
Muscle weakness/fatigue	**Sudden energy drop**	**Strong thirst For hot, cold or room temp drinks?**_____	
Are you typically colder than those around you?		**Warmer?**	**Hot Flashes**

Is your libido: Low? Medium? High?

Skin and Hair

Rashes	**Ulcerations**	**Hives/Allergic Dermatitis**	**Itching**
Eczema/Psoriasis	**Dandruff**	**Loss of hair**	**Recent moles**
Skin discoloration	**Acne**	**Change in skin/hair texture**	**Face flushing**
Greasy hair	**Warts**	**Fungal Infection**	**Weak nails Ridged?**
Dry hair	**Oily skin**	**Dry skin**	**Redness of skin**

Head, Eyes, Ears, Nose and Throat

Sinus pain	**Difficulty swallowing**	**Migraines**	**Glasses/contacts**
Eye Strain	**Eye pain/dryness**	**Poor vision**	**Poor night vision**
Dark circles under eyes	**Cataracts**	**Blurred vision**	**Earaches**
Ringing in ears	**Poor hearing**	**Spots in front of eyes**	**Sinus congestion**
Nose bleeds	**Recurrent sore throats/colds**	**Grinding teeth**	**Frequent sneezing**
Sores on lips/tongue	**Headaches**	**Jaw clicks/locks**	**Frequent runny nose**

Name_____ **Date**_____

Cardiovascular

Chest pain or pressure	Irregular heart beat	Palpitations at rest	Spider veins
Cold hands/feet	Swelling of hands/feet	Blood clots	Phlebitis
Shortness of breath	Varicose veins	Pressure in chest	High blood pressure
Heart Murmur	Spontaneous sweating	Dizziness	Low Blood Pressure

Respiratory

Cough/Wheezing	Coughing blood	Asthma	Bronchitis
Pneumonia	Pain with deep inhalation	Tight sensation in chest	Difficult inhale/exhale

Difficulty breathing when lying down Production of phlegm… what color? _____
Seasonal allergies When and what are your symptoms?_____

Gynecological/Reproductive (for Women)

Difficult/Painful intercourse	Ovarian cysts	Date of last PAP/Pelvic exam_____
Vaginal dryness	Endometriosis	Number of pregnancies_____
Vaginal sores	Uterine Fibroids/Polyps	Number of live births_____
Vaginal discharge	Fibrocystic breast tissue	Number of miscarriages_____
Vaginal itching/burning	Polycystic Ovarian Syndrome	Number of ectopic pregnancies_____
Frequent vaginal infections	Nipple discharge	Number of abortions_____
Irregular menstruation		Number of stillbirths_____
Pelvic adhesions/scarring	Pelvic/tubal infection	Abnormal Pap test When?_____
Pelvic pain	Infertility	Breast Pain
Herpes	Chlamydia	Gonorrhea Genital warts

Do you use birth control?_____What type?_____ How long this type?_____
Have you ever used hormonal birth control?_____ What type?_____ When?_____
Used IUD? What type? _____ When?_____

Attempting Pregnancy currently? If so, for how long? _____
Currently Pregnant? If so, how far along _____ Currently breastfeeding? If so, how long?_____
Difficult scanty or painful lactation Premature deliveries? If so, when?_____
Post-partum difficulties? Describe_____
Difficult deliveries? Describe_____
Difficulties in pregnancy? Describe_____

Age of first menses _____ What was it like for you? _____
Date of last menses_____ Recent menstrual changes? If so, what type_____
How many days do you normally bleed?_____ How many days between periods? _____
How heavy is the bleeding? Light Medium Heavy How often do you change pads/tampons? Every _____ hours
What color is the blood? Pale red Pink Red Dark red Purple Brown Black
Is the blood: Watery Clotted Contains Mucus Thick Strong odor

Painful periods? If so, how many days does pain last? _____ What makes the pain better? _____
Heaviness or pressure in pelvis with periods
Have you ever gone more than 2 months without getting your period? When?_____
PMS? What symptoms_____ When do they start?_____
Bleeding/Spotting between periods? When in cycle _____
Do you ovulate regularly?_____ If so, on what day of your cycle?_____ Is ovulation painful?_____
Do you observe cervical mucus changes with ovulation?_____ Bleeding with ovulation?_____
Do any of your symptoms seem to change or worsen around you period? How?_____
Menopausal Symptoms?_____
Any other menstrual or reproductive concerns?_____

Name _____ **Date**_____

Gastrointestinal

Nausea	Vomiting	Diarrhea	Constipation
Gas	Belching	Black stools	Blood or mucus in stool
Indigestion/gurgling	Bad breath	Rectal/Anal pain	Hemorrhoids
Bloating/Edema	Strong smelling stools	Loose stools	Abdominal pain/cramps
IBS	Acid reflux/GERD	Hernia	Sticky stools
Excessive hunger	Frequent hiccoughing	Crohn's Disease	Food in stools

How often do you have a bowel movement? _____time(s) every _____days.

Urinary

Pain on urination	Frequent urination	Blood in urine	Urgent urination
Unable to hold urine	Cloudy urine	Scanty flow of urine	Copious flow of urine
Impotence	Sores on genitals	Dribbling after urination	Burning urination
Night urination How often?_____		Urinary tract infection(s)	Concentrated urine

Musculoskeletal

Neck pain	Shoulder pain	Hand/wrist pain	Facial pain
Knee pain	Sprains/Strains	Sciatica	Foot/ankle pain
Hip pain	Muscle pain/tension	Heaviness of limbs	Jaw Pain or tension/TMJ
Back pain Low___ Middle___ Upper___		Rib area pain	Areas of numbness
Soreness/weakness in lower body (back, knee, hip, ankle, foot)			Heel Pain

For Men

Premature ejaculation	Fatigue after ejaculation	Prostatitis	Infertility
Nocturnal emission	Pain in testicles	Herpes	STD_____
Discharge from penis	Varicocele	Testicular mass	Semen analysis_____

Neuropsychological

Poor concentration	Loss of balance	Vertigo	ADD/ADHD
Lack of coordination	Poor memory/memory loss	Concussion	Depression
Anxiety	Bad temper/rage	Easily susceptible to stress	Seasonal Affective Disorder
Nervousness	Irritability	Panic attacks	Symptoms worse w/stress

Have you ever been treated for a psychological concern?	Yes	No
Have you experienced sexual or physical abuse?	Yes	No
Have you ever considered or attempted suicide?	Yes	No
Have you ever been treated for substance abuse?	Yes	No
Please rate your overall stress level.	Low Medium	High

Are you currently working with a counselor? If so, who?_____
If possible, please describe the most challenging emotion you experience_____
When do you most often feel this emotion?_____
What experiences or activities bring you the most joy and nourishment?_____
_____
Do you feel that you have adequate emotional support in your life? If so, from where/whom?_____
What goals do you have for your acupuncture treatments?_____
_____

LISA TONGEL, LICENSED ACUPUNCTURIST

Privacy Disclosure and Policies

As my patient, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In Office Security
The notes that are taken during appointments are kept in your chart and are secured in the office at all times. If patient charts are in public areas, they are kept with the names covered. Access to this office is limited to practitioners, staff, and supervised guests.

Public Interaction
Should I see you socially, by coincidence or intent, I will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is my preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations
I consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing.

Records Release
Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply
Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Lisa Tongel, Licensed Acupuncturist maintain my records confidentially in accordance with the law. I agree to inform Lisa Tongel, Licensed Acupuncturist if I need any special arrangements pertaining to this issue.

Name - Printed: _____ **Signed:** _____

Date: _____

I acknowledge that I have received a copy of these privacy policies. Initials_____

LISA TONGEL, LICENSED ACUPUNCTURIST
Treatment Informed Consent Form

I hereby voluntarily request and consent to receive acupuncture and Oriental Medicine treatment for my present and future health condition(s). I understand that treatment will be administered by Lisa Tongel, Licensed Acupuncturist. I understand that the acupuncture and Oriental Medicine treatments that I may receive include:

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually aching, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine Treatments: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

Heat Treatments with Moxa or a TDP Lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local non-painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat.

Gua Sha: Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild aching or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pace maker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or aching as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand that Lisa Tongel, Licensed Acupuncturist is an independent practitioner of acupuncture and Oriental medicine; she is not associated with any other practitioner at Anisha – A Center for Holistic Health. I understand that any concerns I have regarding my care should be addressed to Lisa Tongel, Licensed Acupuncturist directly, and that no other party is responsible for the care I receive from Lisa Tongel, Licensed Acupuncturist.

By signing below I show that:
I have read and understand the information in this consent form. I have had the opportunity to discuss the above with Lisa Tongel, L.Ac., and have had all of my questions answered. I understand that I can request more information at any time if desired. I understand the possible risks and complications involved in treatment. I consent to receiving treatment that involves the above procedures. I understand that there are no guarantees concerning treatment, and that there are other treatment alternatives, including those that might be offered by a licensed physician. I understand that I am free to refuse or stop treatment at any time.

Signed_____ Date_____

Printed Name_____ L.Ac. Initials_____

Fertility Treatment History

Please fill out this history as carefully and completely as possible including dates, results, and side effects where appropriate. The more information I have to work with, the better I can understand your body as a whole, and how it has responded to treatment. Thank you for taking the time to complete this form.

Name _____ Age_____ Date_____
Fertility Clinic _____
Physician _____

Western Medical Diagnosis (if any)_____
_____
_____

Western Diagnostic Tests & Hormone Panels (include dates & results)

- ❑ Hysterosalpingogram (HSG) _____
- ❑ Endometrial Biopsy _____
- ❑ Clomid Challenge test _____
- ❑ Follicle Stim. Horm. (FSH) _____
- ❑ Anti-Mullerian Horm. (AMH)_____
- ❑ Leutinizing Horm. (LH) _____
- ❑ Estradiol (estrogen) _____
- ❑ Progesterone _____
- ❑ Prolactin _____
- ❑ Doppler ultrasound (blood flow)_____
- ❑ Hysteroscopy/Saline Infused Sonogram_____
- ❑ Thyroid _____
- ❑ Genetic Testing _____
- ❑ Other Testing _____

GYN related surgeries (dates & outcome)

_____
_____
_____
_____
_____

A.R.T. History (use back if necessary)
Clomid only Cycles (No insemination done**)** Please list each cycle with date, dose used, egg/sperm quality, any complications/side effects, outcome, etc.

_____
_____
_____
_____

Intrauterine Insemination (IUI) Cycles Please list each cycle with date, meds used, egg/sperm quality, any complications/side effects, outcome, etc.

_____
_____
_____
_____
_____
_____

Name_____ **Date**_____

In Vitro Fertilization (IVF) Please list each cycle with date, type of cycle (fresh, frozen, donor, etc.), meds used, # of eggs retrieved and # fertilized, type of fertilization (ICSI, etc), egg/sperm donor or gestational carrier use, PGD use, quality and # of embryos transferred, # of embryos frozen, any complications/side effects, outcome, etc.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Male Factor (please include dates, results and any applicable treatment)

- ❑ Sperm Count (#/cc) _____
- ❑ Sperm Motility (% moving) _____
- ❑ Sperm Morphology _____
- ❑ Sperm Rise ("swim up test") _____
- ❑ Anti-sperm Antibodies _____
- ❑ Varicocele (including surgery) _____
- ❑ Sperm penetration assay (SPA) _____
- ❑ Other male factor concerns _____

_____

Other Past Treatments Please indicate any other forms of past treatment, both conventional and alternative.

_____
_____
_____
_____
_____
_____

Do you have any other comments, concerns, or issues that you would like to discuss?

_____
_____
_____
_____
_____
_____

PATIENT COPY

LISA TONGEL, LICENSED ACUPUNCTURIST

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Name - Printed: _____ **Signed:** _____

Date: _____