Destin Radder, Licensed Acupuncturist, PLLC

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405-0078
www.DestinRadder.com Destin@DestinRadder.com

Welcome!

Thank you so much for your interest in acupuncture and Traditional Chinese Medicine. It is my goal to make every effort to assure that you receive the best quality care. In addition to providing high quality health care I strive to make sure that:

- Customer service always meets the highest standards.
- Any questions you have about your care are answered to your satisfaction.
- Your phone calls are returned promptly.
- Your private health care information is kept secure and private.

Enclosed you will find several forms that I'd like you to fill out and bring with you to your first appointment. If you have any questions about these forms, please call me at 405-0078 or email me at Destin@DestinRadder.com and I will be happy to help you.

There are a few things you can do to make your first appointment as enjoyable as possible.

- Please read the enclosed "What to Expect During a Treatment".
- Please wear loose fitting clothing that can be pulled up at least above your knees and elbows.
- It is also best if you are neither too hungry nor have a full stomach when you arrive. I generally recommend people eating something light an hour before your appointment if possible. When asked I generally recommend a piece of fruit or a bowl of soup.
- Also avoid sedatives like alcohol or stimulants like coffee or nicotine for at least two hours before a treatment.
- It is also best not to engage in heavy exercise two hours before or after your treatment.
- After your treatment it is recommended to drink at least 10 ounces of water.

Again, thank you for making your first appointment. You have taken an important step on the road to more vibrant health. I look forward to serving you.

Yours sincerely,

Destin Radder L.Ac., Dipl. Ac

P.S. Be sure to "Like" Destin Radder, Licensed Acupuncturist. on **Facebook**

P.S.S. Sign up for my email newsletter. Go to **www.DestinRadder.com** and enter your email address.

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What to expect during your first acupuncture treatment

Inquiry Into Your Health

Your first acupuncture treatment will start with an in-depth inquiry into your condition. I will ask many questions directly related to your chief complaint, but I will also ask questions about other, seemingly unrelated aspects of your health.
Chinese Medicine believes that there is a root cause to every ailment that patients feel. This root could be as simple as acute trauma, like falling off a ladder, or the root can also be an aspect of your health that has been festering for many years and has only recently become problematic. Everyone is different, and your unique body type is called your constitution.

Your individual constitution combined with factors like diet and lifestyle create strengths and weaknesses in your health. For example, if someone is under a tremendous amount of stress, certain parts of the body can slowly weaken. The way stress manifests into a health problem is dependent on the individual's constitution. Some people may have a weak digestive system, so emotional stress will manifest as acid reflux, ulcers, or Irritable Bowel Syndrome (IBS). Other people may have a constitutional weakness in their lungs, so stress manifests as asthma.

We, as Chinese Medicine practitioners, don't just treat symptoms because the symptoms you feel are often clues about a deeper problem. We have to treat the root of the problem or the same symptoms, or similar symptoms will reappear. Clinically, some patients get discouraged because they just want to relieve the symptoms and continue the lifestyle that made them seek treatment in the first place. It is important to understand that regardless of the symptoms, there is a usually a deeper problem that has to be addressed if complete healing is going to occur.

In my years of practice I have identified poor diet and stress as the root cause of many ailments. For this reason, I believe healing is a partnership that needs participation from both practitioner and patient. At times it is necessary for a patient to change his/her diet or lifestyle for full healing to occur.

What a Needle Insertion Feels Like

After gathering health histories, I give patients a brief summary of what to expect during their treatment. As mentioned previously, acupuncture needles are sterile, single use instruments that are approximately the thickness of a cat's whisker, or a very thick hair. One of the most frequent questions I get is, "Do the needles hurt?" Unfortunately there is no one answer because everyone is different. Some patients are not bothered by the insertions, others feel the insertions more. Needle insertions into some parts of the body, like forearms and calves, are hardly felt. However some areas of the body are sensitive, like hands and feet.

When a needle is inserted a patient can feel a number of different sensations including; nothing, the patient can feel like a small needle is being inserted in their skin, he or she can feel pressure similar to a finger pressing on his or her skin or can even feel a radiating sensation to their fingers or toes. No matter what the patient feels, the sensation of the needle being inserted should fade in about 5 seconds to a minute. If there is an uncomfortable sensation beyond 60 seconds, I encourage patients to tell me so the needle can be repositioned. The experience of acupuncture should be very relaxing once the needles are inserted.

What to Expect From The Treatment

One of four experiences can typically be expected after the first acupuncture treatment. The first can be an immediate decrease of the pain or discomfort. The patient can feel a decrease in severity of symptoms, a

change of location of the symptoms/pain or a change in the quality of symptoms. Patients have gotten up after the treatment very pleased that their symptoms changed significantly during the treatment.

A second possibility is that there is no change in the chief complaint immediately after the treatment but a delayed effect, a decrease in pain or discomfort later that day or even the next day. I have had patients get up after the treatment and report no change to their condition, but upon returning he or she reported that approximately 12 to 24 hours later he or she felt a significant improvement.

A third possibility is that symptoms can get worse before they get better. I have had patients report that their pain or discomfort actually increased later that day or that night but then experienced a significant decrease in pain or discomfort upon waking or later the next day.

The fourth possibility is that nothing happens and there is no change. This may be due to the fact that the chief complaint has been present for so long that multiple treatments may be necessary before relief is felt or that possibly acupuncture is not that particular patient's solution. I believe it is important to be honest with patients and let them know that acupuncture is not magic nor it is 100% successful. There is no medical system in existence that is 100% effective and that goes for acupuncture too. Chinese Medicine is a valid and effective medical system and like others, and it has strengths and weaknesses.

During the first few treatments, improvement of symptoms typically last for 12 to 72 hours and then start to fade. This is because your body is in a habit of dysfunction. We have to condition the body to return to balance and health which requires frequent treatments in the beginning of the treatment process. Each treatment I attempt to decrease the pain and increase the amount of time the patient feels relief of pain and symptoms, so that patients can reduce the frequency of required treatments.

How Many Treatments Will I Need?

Every patient is different. Everyone's body is different and everyone's health issues are different. Everyone's healing path is different also. Some people progress very fast and some take more time.

In the beginning 2 treatments a week are common. I tell patients that if they can come in 2 times a week for 2-3 weeks, a total of 4-6 treatments, they can get a very good idea of how well they will respond to acupuncture. If the patient responds well, appointments can be decreased to once a week. When the reduction of discomfort spans treatment to treatment then I feel comfortable extending the treatments to once every two weeks. This pattern continues until ultimately the patient only returns for "tune ups", every 1 to 2 months.

What Happens After the Needles Are Inserted

Once the needles are inserted and the patient is comfortable, it is time for the patient to rest. I turn on relaxing music and turn the lights down to encourage complete tranquility. Stress destroys health but relaxation rejuvenates and restores health. It is this time that the needles do their work and the patient can assist the process by sitting back and relaxing. Typically during the first treatment the patient will rest approximately 15 minutes. The time is gradually increased to about 30 minutes as the patient returns for follow up treatments. Patients report this time as being not only relaxing but rejuvenating, restoring and refreshing. It is not unusual for me to return to find the patient sleeping.

When I return to the room I remove the needles, which typically is a painless procedure, the patient gets up and puts on his or her shoes. At that time I typically will inquire if the patient has any questions. When the patient is ready and all questions have been answered, he or she will leave the treatment room and the appointment is over.

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Patient Health History

PLEASE BRING WITH YOU TO YOUR FIRST APPOINTMENT

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Print all information and indicate areas of confusion with a question mark. If you have any questions please ask, call, or email me. Thank you very much for your patience.

I know this form is lengthy but please complete this questionnaire as thoroughly as possible.

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Your main doctor's name:_____ Phone #: (___)_____

When was your last physical exam? _____/_____/_____ Doctor's name:_____ Phone # (____)_____

Please identify the health concerns that have brought you to this clinic in *order of importance* below:

Symptom #1 (*If your chief complaints are not pain related please go to page 2*)

Location of pain_____ Cause of Pain _____

Type of pain: ___Sharp __ Dull __Aching __ Burning __Throbbing __Numbness __Tingling __Spasm

Is it: __ Constant __ Intermittent Does it Radiate? __Yes __No Where?_____

Pain Scale: (Circle number) 0 (no pain)
1 2 3 (mild, doesn't force me to change my routines)
4 5 6 (moderate, occasionally forces me to change my routine)
7 8 9 (severe, my life revolves around my pain)
10 (excruciating)

Pain frequency: % of your day you feel pain/discomfort 0 - 25% 25 - 50% 50 - 75% 75 - 100%

Pain Intensity: Doesn't effect activities Somewhat effects activities Seriously effects activities

What makes pain worse? _____ What make pain better?_____

How long have you had present pain?_____Have you had the pain in the past? How long?_____

Symptom #2

Location of pain_____ Cause of Pain _____

Type of pain: ___Sharp __ Dull __Aching __ Burning __Throbbing __Numbness __Tingling __Spasm

Is it: __ Constant __ Intermittent Does it Radiate? __Yes __No Where?_____

Pain Scale: (Circle number) 0 (no pain)
1 2 3 (mild, doesn't force me to change my routines)
4 5 6 (moderate, occasionally forces me to change my routine)
7 8 9 (severe, my life revolves around my pain)
10 (excruciating)

Pain frequency: % of your day you feel pain/discomfort 0 - 25% 25 - 50% 50 - 75% 75 - 100%

Pain Intensity: Doesn't effect activities Somewhat effects activities Seriously effects activities

What makes pain worse? _____ What make pain better?_____

How long have you had present pain?_____Have you had the pain in the past? How long?_____

If your chief complaints are pain related and you filled out page 1, you can skip this section and go onto the next page.

Please identify the health concerns that have brought you to this clinic in *order of importance* below:

Condition **How/when were you last treated for this condition**

A. _____ _____

_____

_____

How does this condition affect you? _____

_____

_____

B. _____ _____

_____

_____

How does this condition affect you? _____

_____

_____

C. _____ _____

_____

_____

How does this condition affect you? _____

_____

_____

D. _____ _____

_____

_____

How does this condition affect you? _____

_____

_____

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

_____

_____

_____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

Drug name	Reason for taking	For how long?	Dose & Strength	Frequency

Please list all supplements or herbs you are currently taking:

Supplement/Herb name	Reason for taking	Potency (mg or IU, etc.)	Dose	Frequency

Are you vegetarian or vegan? Y N If yes how long?_____

Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _____

Family History:	Father	Mother	Brothers	Sisters	Spouse	Children	Children
Check those applicable:							
Age (if living)	_____	_____	___ ___	___ ___	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	___ ___	___ ___	_____	_____	_____
Cancer	_____	_____	___ ___	___ ___	_____	_____	_____
Diabetes	_____	_____	___ ___	___ ___	_____	_____	_____
Heart Disease	_____	_____	___ ___	___ ___	_____	_____	_____
High Blood Pressure	_____	_____	___ ___	___ ___	_____	_____	_____
Stroke	_____	_____	___ ___	___ ___	_____	_____	_____
Mental Illness	_____	_____	___ ___	___ ___	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	___ ___	___ ___	_____	_____	_____
Kidney Disease	_____	_____	___ ___	___ ___	_____	_____	_____
Age (at death)	_____	_____	___ ___	___ ___	_____	_____	_____
Cause of Death	_____	_____	___ ___	___ ___	_____	_____	_____

Height: _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

Blood Pressure: What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles Rubella Chicken Pox

Others:_____

Immunizations (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

Infectious Diseases:

Do you have any infectious diseases? Y N If yes, please identify: _____

Hospitalizations and Surgeries:

Reason	When	Reason	When

X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason	When	Reason	When

Traditional Chinese Medicine Pattern Identification:

Energy Level: 1 2 3 4 5 6 7 8 9 10
lowest possible **best imaginable**

Stress Level: 1 2 3 4 5 6 7 8 9 10
lowest possible **most imaginable**

Please go through and check anything that you think applies to you. If you have a symptom that is in more than one box, check that symptom wherever it appears. Ex. If you have abdominal pain check that symptom in Box 2 and Box 4

Box 1
LU & LI

- ☐ Allergies
- ☐ shortness of breath
- ☐ Asthma/wheezing
- ☐ Spontaneous sweating
- ☐ Dry cough
- ☐ Cough with phlegm
- ☐ Eczema/psoriasis/ rash
- ☐ Dry mouth/thirst
- ☐ Weak voice
- ☐ Chronic sinus infections
- ☐ Frequent colds
- ☐ Frontal/sinus headache
- ☐ Grief/sadness
- ☐ Nasal problems
- ☐ Diarrhea w/ mucus
- ☐ Diarrhea w/ blood
- ☐ Chronic constipation
- ☐ Bowel movement w/ burning
- ☐ Stiff joints/neck
- ☐ Wheezing/ shortness of breath
- ☐ Fatigue/tired
- ☐ Flatulence
- ☐ Pebble-like feces
- ☐ Fatigue after bowel movement

Box 2
SP,ST

- ☐ Abdominal pain/ discomfort
- ☐ Aching/heavy limbs
- ☐ Anemia
- ☐ Appetite
- ☐ Digestive problems
- ☐ Belching
- ☐ Heartburn
- ☐ Bruise easily
- ☐ Bruise easily
- ☐ Colic/indigestion
- ☐ Distention/bloating
- ☐ Stomach pain/ Gastritis
- ☐ Headaches
- ☐ Hiccups
- ☐
- ☐ Irritable bowel
- ☐ Lethargy/fatigue
- ☐ Loose stools
- ☐ Muscle weakness
- ☐ Nausea/vomiting
- ☐ Poor memory
- ☐ Prolapse
- ☐ Worry/over thinking

Box 3
LR, GB

- ☐ Anger/irritable/ temper
- ☐ Blurry vision/ floaters
- ☐ Breast tenderness
- ☐ Brittle coarse hair/ nails
- ☐ Bruising
- ☐ Depression
- ☐ Dream disturbed sleep
- ☐ Flatulence
- ☐ Headaches
- ☐ Indigestion
- ☐ Irritable bowel
- ☐ Menstrual irregularities
- ☐ Migraines
- ☐ Nausea/ vomiting
- ☐ PMS
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Tension/cramps
- ☐ Tinnitus(high pitch)
- ☐ Distention/ bloating
- ☐ Eye/vision problems

Box 4
HT,SI

- ☐ Abdominal pain
- ☐ Anemia
- ☐ Anxiety/dread
- ☐ Digestive troubles
- ☐ Elbow/shoulder pain
- ☐ Hearing problems
- ☐ Heart issues
- ☐ Distention/bloating
- ☐ Eye/vision problems
- ☐ Hot painful joints
- ☐ Insomnia
- ☐ Lack of joy/humor
- ☐ Mouth/tongue sores
- ☐ Muscle tone
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Sleep problems
- ☐ Tongue/speech issues
- ☐ Restlessness
- ☐ Upper back pain
- ☐ UTI

Box 5
KD,UB

- ☐ Adrenal weakness
- ☐ Backache/weak knees
- ☐ Bladder infection
- ☐ Bladder control
- ☐ Brittle bones
- ☐ Cold hands/feet
- ☐ Dark/puffy around eyes
- ☐ Depression/fear
- ☐ Impotence/ libido
- ☐ Infertility
- ☐ Lack of stamina
- ☐ Lethargy/ fatigue
- ☐ Loss/thinning hair
- ☐ Poor memory
- ☐ Premature gray
- ☐ Foggy headed/ Senility
- ☐ Sore throat in a.m.
- ☐ Tinnitus (low)
- ☐ Urine frequency
- ☐ Will power
- ☐ Edema/water retention
- ☐ Sciatica/lumbago

Circle all answers that apply.

Sleep: Difficulty falling asleep Wake frequently at night Wake early and can't go back to sleep
Light sleeper Heavy sleeper Frequent dreaming Nightmares
Don't feel rested in the morning Feel rested in the morning
Anything else you want to tell me not listed here:_____

Sweating: Night sweating Sweating without activity/anxiety Normal sweating with activity only
Sweaty palms/feet
Anything else you want to tell me not listed here:_____

Appetite: Always feeling hungry Appetite seems normal Rarely feel hungry Aversion to food
I eat more than I should. I eat the right amount for me. I eat less than I should
I prefer: Hot food Cold food Spicy Salty Sweet Bitter Sour Bland
Anything else you want to tell me not listed here:_____

Thirst: Always feeling thirsty Thirst seems normal Rarely feel thirsty Aversion to drinks
I drink more than others. I drink the right amount for me. I drink less than others.
I prefer: Hot drinks Room temperature Cold drinks
Anything else you want to tell me not listed here:_____

Bowel Movements: Regular Irregular Mostly regular Laxative use:_____
Every day Multiple times a day Every other day 1-2/week less than 1-2/week
Dry/Hard Sticky Loose/soft Watery Undigested food bits Painful
Black/tarry Brown Green Yellow Gray/Silver Blood Mucus Other:_____
Anything else you want to tell me not listed here:_____

Urination: More than fluid intake Proportional to fluid intake Less than fluid intake
Clear Light Yellow Dark Yellow Brown Pink/Red Cloudy Frequent UTIs
Pain with urination Frequent urination Urgency Difficulty stopping/starting
Get up at night to urinate Once Twice Three or more times
Anything else you want to tell me not listed here:_____

Temperature: Hot when others are cold Always hot Cold when others are comfortable Always cold
Appropriate for surroundings
Anything else you want to tell me not listed here:_____

Moisture: Dry: skin/lips/throat/scalp Oily skin Constant runny nose Vaginal discharge
Anything else you want to tell me not listed here:_____

Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Depression Anxiety Irritability Frequent anger Memory Loss
Often fearful Frequent crying

Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Easy Bruising Chronic Infections Chronic Fatigue

Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Frequent Nausea/Vomiting Stomach Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Female Reproductive/Breasts (please circle any that you experience now and underline any that you have experienced in the past):

Do you have a monthly period? Yes No If No why?_____

Premenstrual Problems: Breast tenderness/sensitivity Bloating/distention Irritability Fatigue

Abdominal pain: Before period During period After period

Bleeding: Heavy Medium Light Between Cycles Dark Red/Brown Red Light red/pink Clots

Vaginal Discharge **Menopausal Symptoms:** Hot-flashes Night-sweats Fatigue Emotional Vaginal dryness Insomnia

Menstrual/Birthing History:

1. Age of First Menses: _____
2. # of Days of Menses: _____
3. Length of Cycle: _____ Irregular?_____
4. Birth Control Type: _____
5. # of Pregnancies: _____
6. # of Miscarriages: _____
7. # of Abortions: _____
8. # of Live Births: _____
9. Infertility/difficulty conceiving: Y N

Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else you want me to know? _____

_____

_____

_____

_____

Lifestyle:

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

Please give a example of a typical meal: Breakfast:_____

Lunch_____ Dinner_____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____ Employer: _____

Hours/Week: _____

Do you enjoy work? Y/N Why/Why not?_____

g. Habits. Please circle any that apply:

Coffee:	cups per day _____	age started _____	if quit when _____
Tobacco:	# cigarettes/ day _____	age started _____	if quit when _____
Marijuana:	use per day _____	age started _____	if quit when _____
Alcohol:	drinks per day _____	age started _____	if quit when _____
Other: _____	use per day _____	age started _____	if quit when _____

Do you drink diet soda, chew sugarless gum or use artificial sweeteners(i.e. Equal®, NutraSweet®, Spoonful®) Y N

h. Have you experienced any major physical or emotional traumas? Y N
Explain:_____
_____

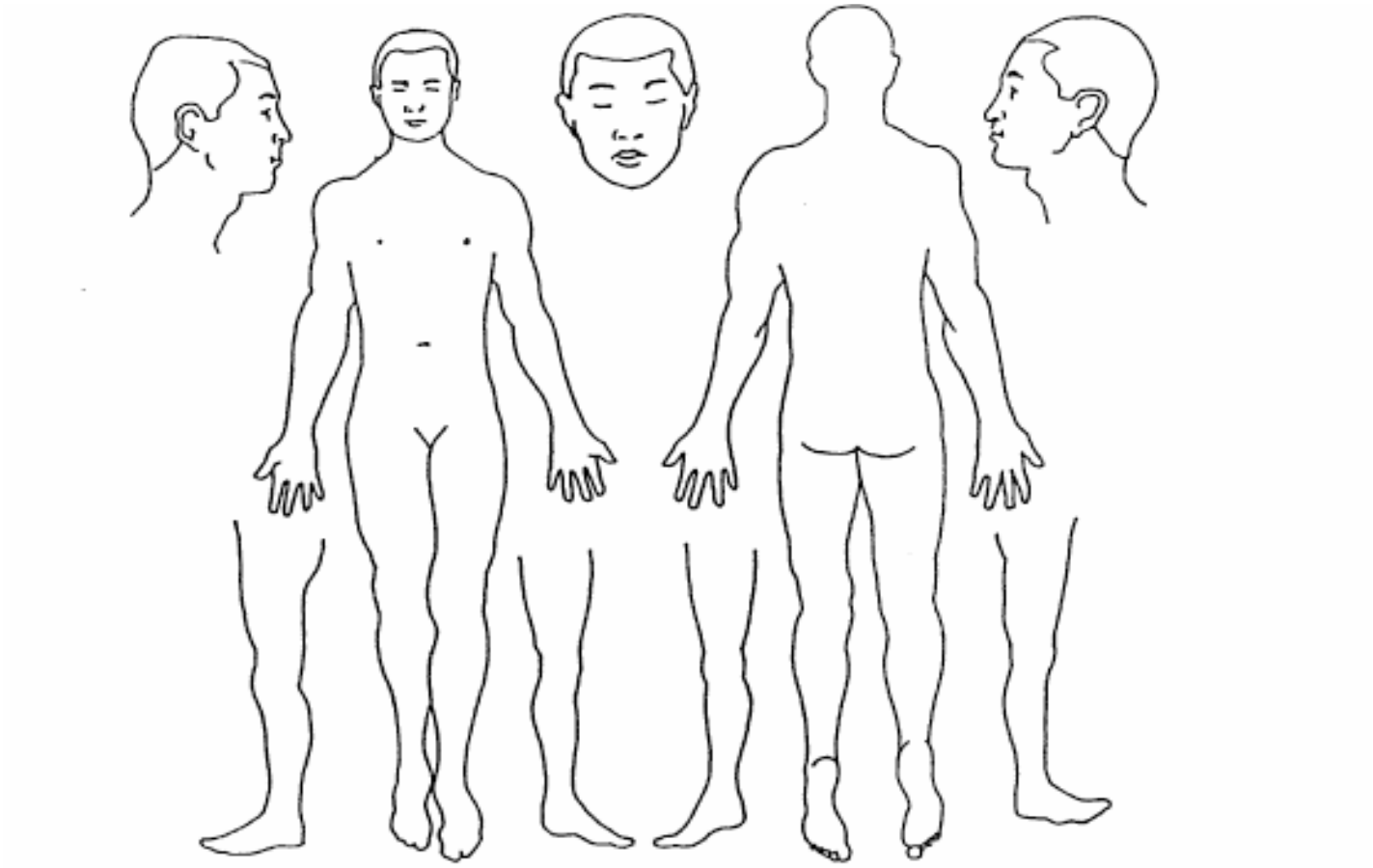
i. How many glasses of water do you drink per day? _____

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

l. Please write below anything else you would like me to know about your condition.

35. **Pain Location Chart** *(Mark the areas of pain on diagram and describe below):*



Area/Description of Symptoms	Pain Level: 0 to 10 (10 being the highest)	Frequency (times/day or week)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the acupuncturist of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Patient's Signature_____**Date**_____

Practitioner's Signature_____**Date**_____

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Traditional Chinese Medicine price list

Initial Appointment with acupuncture	90 minutes	$125
Consultation without acupuncture	30 minutes	$30
Follow up acupuncture appointment	60 minutes	$60
Initial Herbal Consultation	90 minutes	$85
Herbal Consultation	30 minutes	$30
Nutritional Consultation	30 minutes	$30

Smoking Cessation

The smoking cessation protocol consists of an initial appointment and 3 follow up appointments for a total of four treatments.

Follow up appointment	45 minutes	$45

Pre-paid price list

Pay for your treatments ahead of time and receive a discount.

Number of Treatments	Regular price	Discount	Discounted Price Per Treatment	Discounted Total Price
4 Treatments	$240	10%	$54	$216
6 Treatments	$360	12.5%	$52.50	$315
8 Treatments	$480	15%	$51	$408
12 Treatments	$720	20%	$48	$576

Insurance Coverage

Full Coverage	**Coverage Dependent upon Individual Plans**	**20% Discount (follow up acupuncture appointments only)**
No Fault Insurance	Flex Fit plans Health Savings Account	Independent Health