

Bonnie McLean, D.O.M., A.P., R.N.

WELCOME

GENERAL INFORMATION

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Married _____ Single _____ Partner _____ Divorced _____ Widow _____ Date of Birth _____

Work Phone _____ Home Phone _____ Cell # _____

Email _____ Occupation _____

Emergency Contact _____ Referred By _____

Family Physician _____ Phone number _____ May we contact them? Y/N

Are you presently under a doctor's care? Y/N For what? _____

Have you had Acupuncture or Oriental Medicine before? Y/N Where _____

Are there any other therapies in which you are involved? Y/N Who and for what _____

INSURANCE INFORMATION (Only complete if this is Personal Injury – P.I.)

Insurance Company _____ Group/Plan # _____

Contact number _____ Contact name _____

Referral _____ Date of accident _____

MEDICAL HISTORY

Do you have any allergies? Y/N If so, to what _____

Do you take medication? Y/N If so, what? _____

Do you take a blood thinner? Y/N _____

Do you take supplements? Y/N If so, what types and how often _____

Do you have any contagious diseases? Y/N What kind? _____

Please indicate if you or any family members have or have had any of the following conditions:

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Drug reaction | <input type="checkbox"/> Mental breakdown | <input type="checkbox"/> Gonorrhea/Herpes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Jaundice | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Parasites | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Hypo/hyper thyroid | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles | <input type="checkbox"/> Premature graying |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Obesity | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis |

FOCUS

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____ Better? _____

Place an X next to the areas of your life that are affected:

Sleep _____ Work _____ Walking _____ Sitting _____ Exercise _____

Travel _____ Recreation _____ Mental State _____ Relationships _____

What have you done about this? _____

What are other reasons for your visit? _____

- Are you interested in:
- | | | |
|--|--|--|
| <input type="checkbox"/> Pain Relief | <input type="checkbox"/> Smoking Cessation | <input type="checkbox"/> Maintenance Care |
| <input type="checkbox"/> Stress Relief | <input type="checkbox"/> Weight Management | <input type="checkbox"/> Fertility |
| <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Herbal Therapy | <input type="checkbox"/> Wellness & Lifestyle Counseling |
| <input type="checkbox"/> Other _____ | | |

What are your health goals? _____

List any past or future surgeries _____

List any significant trauma (auto accident, falls, emotional, sexual, etc.) and when they occurred _____

List exercise and sport activities you have been or are currently involved in _____

WELLNESS SURVEY

Do you sleep well? Y / N Do you dream? Y / N

Do you smoke? Y / N How much? _____ Do you drink alcohol? Y / N How often? _____

Do you use caffeine? Y / N Do you use sugar? Y / N Do you use a sugar substitute? Y/N What? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

FEMALE CONCERNS

Date of last menstruation _____ Is your cycle regular? Y / N Is your cycle painful? Y / N

Have you ever been pregnant? Y / N Are you on birth control? Y / N How long _____

- PMS Clotting Vaginal sores Vaginal pain Discharge

___ Difficulty getting pregnant



Doctor of Oriental Medicine

107 Baybridge Drive ● Gulf Breeze, FL 32561 ● Ph. (850) 932-1778

Authorization, Releases, and Terms of Acceptance

I, the undersigned, hereby authorize Bonnie McLean D.O.M., A.P., to perform diagnostic tests and to administer treatment as necessary. Treatment will include Oriental Medicine (acupuncture, gua sha, cupping, herbology) and may include lifestyle counseling, nutritional counseling, vibrational medicine, clinical hypnosis, and coaching regarding self-healing techniques.

I understand that this treatment is designed to balance the Qi (energy) of my body for the purpose of balancing my body and promote my own self healing process. I understand that Bonnie McLean D.O.M., A.P. does not offer to diagnose or treat any disease or condition other than the quality, quantity and balance of my body's own Qi.

I also certify that I will use Chinese Medicine in conjunction with and not as a substitute for care under my primary care physician. I also understand that the purpose of this practice of Oriental Medicine is restorative and preventive, not emergency treatment. I certify that no guarantee or assurance has been made to the results that may be obtained.

I have read or will read the information given on Oriental Medicine and acupuncture and the possible side effects. I agree to research and ask about anything about Oriental Medicine and the healing tools used my treatment that I don't understand.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I understand and agree that, even in the cases where the office assists me in billing for my care, all services rendered to me are my responsibility. Unless other arrangements have been made, I agree to pay for my service at the time of my service. I understand that I am responsible for my own financial records for personal and tax purposes.

Patient's signature _____ date ____/____/____
Patient's guardian _____ date ____/____/____

SYMPTOMS

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Abdominal pain/distention | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Dark stools | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Muscle cramps/pain | <input type="checkbox"/> Seeing a therapist |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Hiccup | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Short temper |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Impotence | <input type="checkbox"/> Night sweat | <input type="checkbox"/> Sinus pressure |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Dry throat/mouth | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Skin fungal infection |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Spots in eyes |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Earaches | <input type="checkbox"/> Intestinal pain | <input type="checkbox"/> Numbness | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Irritable | <input type="checkbox"/> Odorous stools | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Breast lump/pain | <input type="checkbox"/> Eye pain/strain | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Itchy skin | <input type="checkbox"/> Peculiar tastes | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Chest pains | Color of | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Teeth/gum problems |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Fever | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas/belching | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Wake to urinate |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Migraine | <input type="checkbox"/> Rash | <input type="checkbox"/> Weight loss/gain |
| | <input type="checkbox"/> Headache | <input type="checkbox"/> Mouth Sores | <input type="checkbox"/> Redness of eyes | <input type="checkbox"/> Wheezing |

P = Pain

N = Numbness

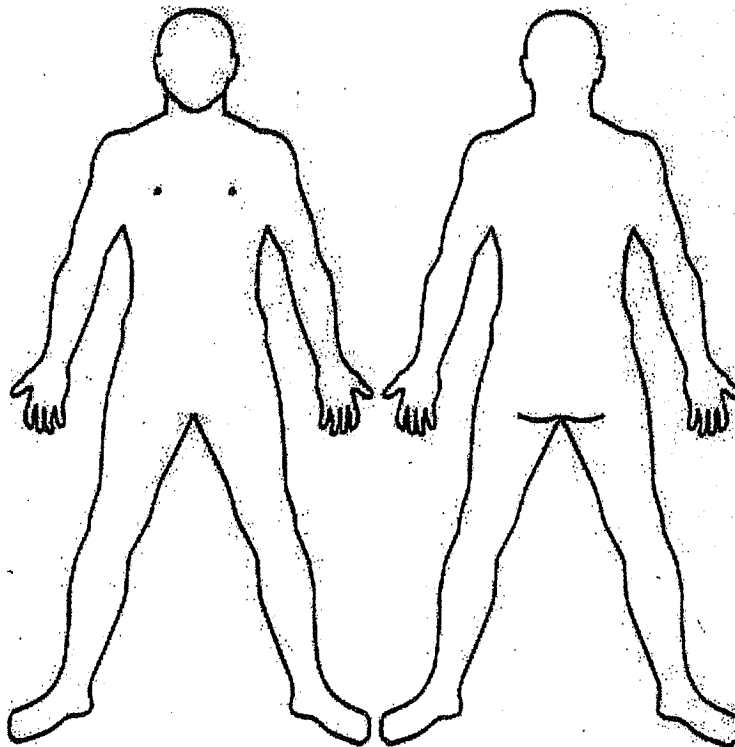
T = Tightness

R = Restriction

S = Spasm

On the diagram below and with the appropriate letters above, please mark in bold to indicate your areas of pain.

On the diagram below and with the appropriate letters above, please mark in light to indicate your areas of discomfort.



Bonnie McLean O.M.D., A.P., M.A., R.N.
Doctor of Oriental Medicine
Acupuncture Physician

Initial Consultation and Treatment	\$75/ 1 hr.
Regular Follow-Up	\$65/45 min.
Single problem	
Tune up	
NAET Allergy Treatment	
Habit control Treatment	
Extensive Follow-Up	\$80/1 hr.
Wellness counseling and healing session	
Emotional clearing session	
Treatment of multiple problems	
Hypnosis	(\$85 if taped)
Consultation only	\$25/ 30 min.
Stress Management only	\$40/30 min.
Pediatric Treatment	\$20-35/20-30 min.
Habit Control Program	\$20 consultation \$180/ 3 day series
No Show and return check fee	\$35
Appointments canceled less than 24 hours notice	\$20
Ask about the Community Acupuncture Clinic	\$20 for group ear acup. \$35-\$50 for indiv. acup.

Ask about discounts for checks and cash, packages, and referrals.

Credit cards accepted: Visa and Master Card

Gift certificates are available should you wish to gift a friend or loved one with an acupuncture treatment.

Payment is due the day of treatment. Please tell Dr. Bonnie if you would like an insurance form filled out for you to submit to your insurance company.

WHAT IS CHINESE MEDICINE?

Chinese Medicine is about 5,000 years old. It is originally based on Taoist philosophy which speaks about the human body in terms of energy rather than matter. The ancient Chinese believed that a basic life energy called qi or chi is present in every living creature, and that it circulates along specific pathways in the body called meridians. As long as energy flows freely through these pathways, the balance (homeostasis) of the body is maintained and the body is healthy. When the flow of energy is blocked for any reason, this energetic system is disrupted and pain or illness results. This can occur in the case of injury, disease, use of alcohol or drugs, lack of exercise, poor nutritional status, weakness from birth, or even chronic mental or emotional anguish. By stimulating appropriate acupuncture points along the energy pathways, the blocked energy is released and health can be restored.

Along these energy meridians are acupuncture points. These points may be stimulated by a number of methods. The most commonly used method is acupuncture, the insertion of very fine solid sterile needles. Other methods may include stimulation by heat, cold, pressure, electricity, a burning herb called moxa, and lasers. The acupuncture meridians and blood circulation can also be stimulated by friction and suction which can be accomplished by the techniques of gua sha and cupping. These two techniques create a temporary bruising effect which will disappear in a few days. Chinese herbal formulas are also an important part of Chinese Medicine.

Research in the Eastern and Western parts of the world has shown that acupuncture stimulates the neurotransmitters in the brain and spinal cord. These are the substances that are responsible for proper transmission of nerve impulses and our sense of well-being. The best known of these are the endorphins which are endogenous morphine-like substances. Studies have also shown that acupuncture can produce physiological reactions in the body, such as changes in heart rate, blood pressure, brain activity, blood chemistry, endocrine functions, intestinal and gastric activity, and immunologic reactions.

Chinese Medicine can be used to treat a wide range of conditions. These can include sprains, strains, and other injuries such as whiplash: neck, shoulder, and low back pain; sciatica; tension, migraine, and sinus headaches; osteoarthritis and bursitis; anxiety and depression; female disorders; asthma; and gastro-intestinal disorders. In the U.S. acupuncture is best known for treating pain conditions, stress-related disorders, and addictions.

The frequency and duration of acupuncture treatments varies according to the type, chronicity, and seriousness of the problem, as well as the general condition of the patient. The effect of acupuncture tends to be cumulative. An average course of treatment may be twice a week for 4-6 weeks, although treatment for detoxification from drugs or medications for severe pain may be daily for 3-7 days. Chinese Medicine addresses the unique needs and situation of each person. This is different from our usual "cook book approach" and expectation of a "quick fix" that we often find in Western Medicine.

Bonnie McLean O.M.D., A.P., M.A., R.N.

Dear everyone:

It is my desire to serve as wide a range of needs and pocketbooks as possible. In order to do this, I offer a community clinic and have created a "menu" from which you may choose when you schedule individual appointments. Please look it over carefully and keep a copy of it, so that you may indicate to the receptionist the amount of time you would like for each session. If there is no indication otherwise, you will be booked for a regular follow-up session.

When you schedule your **initial consultation and treatment** or when you schedule an **extensive follow-up**, you will be my primary focus during that hour. This is especially the case in the hypnosis and emotional clearing sessions. If you would like a tape of your hypnosis session, please let me know ahead of time and bring in a blank standard or miniature tape. You may also request an individualized tape recording after the session. There is a \$40 charge for this service.

When you schedule a **regular follow-up**, you will most likely be sharing my time and attention with another person. If you feel you need my full attention that day, please schedule an extensive follow-up session.

The **Community Acupuncture Clinic** is conducted on a first come/first serve basis. During this clinic there will be some availability for individual acupuncture treatments, depending on space available and the number of participants being treated in the group. If the clinic is busy, I may not be able to offer individual sessions that day. The amount charged for an individual session depends on the time and extensiveness of the treatment.

I would also like to remind you that the more you educate yourself about your health challenges, the better you can participate in your healing process. Taking an active role in your healing and health is self-empowering and cost effective! Please take a look at my webpage www.spiritgatemedicine.com. I am constantly adding information and links to helpful resources. There is also the information about the Community Acupuncture Clinic and my local TV show "Staying Healthy" which airs the last Saturday of the month at 7:30P WUWF Channel 4. I have some very interesting guests from the healing and medical community who provide some wonderful information on a variety of health issues. I hope you will also e mail me at twyndragon@cox.net, ask me questions, and keep me up to date with how you are doing.

During these challenging times, staying healthy is more important than ever. I hope these changes will be helpful in meeting each person's needs more completely. Thank you for choosing me as your health care provider.

With warmest wishes!

Dr. Bonnie

