East-West Wellness Center
Acupuncture, Nutrition and Herbal Medicine
www.East-WestWellness.com
Phone: (215) 322-7733
Fax: (215) 322-7743
82 Buck Road, unit A,
Holland, PA 18966

Welcome to Our Practice

Thank you for choosing our office to meet your health care needs. In addition to acupuncture, you will have access to nutritional counseling, herbal medicine, lifestyle counseling, and a broad array of diagnostic testing. Our goal is to provide a safe, healing environment and to support you in your pursuit of optimal well-being.

Your initial visit may take up to two hours. Please plan your schedule accordingly. We will do a thorough health interview and history, and then partner with you to develop a personalized treatment plan. You will have ample time to ask any questions you may have.

Please note that because this time has been reserved especially for you, we request notification of any scheduling changes a minimum of two business days prior to the first appointment, and one business day prior to established patient visits. Any missed appointments are billed at the regular appointment rate.

To help us better serve you, please take some time to complete and sign the enclosed forms before arriving at your first appointment. If you have recent laboratory test results that you would like to review at the initial appointment, please bring copies, or make arrangements to have them faxed to our office.
If you have any questions, feel free to call us.

We look forward to meeting you soon,

Veronica Bolhovitinova, L.Ac.

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New Patient Comprehensive Health Packet

This packet contains everything you need to get started, including information about our practice, our policies, directions to the office, and new patient forms.

The forms in this packet are for those coming in for a comprehensive health evaluation. These forms ask for detailed information, so please allow some time to fill them out prior to your initial visit.

A note on labs - in our practice we often make use of a comprehensive set of lab tests to evaluate your health. Please bring any previous lab results that you would like us to review with you to your initial appointment, or make arrangements to have them faxed to our office.

We look forward to meeting you soon.

Veronica Bolhovitinova, L.Ac.

About Our Services

We specialize in offering a highly integrated approach to health and wellness, utilizing the best that both Eastern and Western medicine has to offer. Much of what makes our practice unique is a comprehensive process that combines the holistic paradigm of traditional Chinese medicine with the best tools of modern Western science. We begin with a thorough assessment, then create an integrated treatment strategy designed to bring about effective results.

We offer our patients a wide variety of modalities to meet their health care needs:

- Acupuncture
- Herbal Medicine
- Nutritional Counseling & Support
- Lifestyle Counseling
- Stress Management
- Neuro-Emotional Technique
- Nambudripad Allergy Elimination Techniques

Please note: These modalities are described in detail on the "Services" page of our website.

About Veronica Bolhovitinova, L.Ac.

Veronica Bolhovitinova is a licensed acupuncturist, nutritionist, and herbalist providing comprehensive care integrating Eastern and Western medicine to best serve the needs of her patients. Having studied health and nutrition for over 20 years, Veronica earned her Bachelor of Science in Nursing degree in 1997 from the California State University Long beach, and then her Master's degree in Acupuncture from the Eastern School of Acupuncture and Traditional Medicine in Montclair NJ, with advanced training in allergy elimination and nutritional therapies. Veronica is board certified in acupuncture and licensed as a primary care provider by the state of Pennsylvania.

Bringing the best of both worlds together for her patients, Veronica offers a blend of integrative medicine that consists of the holistic modalities offered by traditional Chinese medicine combined with modern Western alternative medical practices. Veronica maintains a private practice in Holland, Pennsylvania where she helps patients living in the local communities as well as New Jersey and surrounding states.

Office Policies and Procedures

Initial Appointment:

 Please allow up to two hours for your initial visit.
 Please arrive 10 minutes early, with your forms completed.
 Any scheduling changes for initial appointments must be made at least 2 business days in advance. Initial appointments that are missed will be charged at the full visit rate.

Cancellations and Changes:
 If you need to reschedule an appointment, please notify us a minimum of 1 business day prior to your scheduled time, so we have time to schedule someone else that is waiting for an appointment.
 If your appointment is on Monday, please notify our office of changes or cancellations no later than noon on the previous Friday.
 Patients who miss their appointment or cancel less than 1 business day prior to their appointment will be required to pay for the missed visit. Missed appointments will be billed to credit card on file.
 Please be respectful to patients on the waiting list, and kindly give us as much advance notice as possible if you need to reschedule.

Your Visits:
 We value our patients' time. In order to keep on schedule, we request that you arrive on time for your appointments. If you arrive more than 15 minutes late for your appointment, it does not allow the necessary time to effectively conduct a treatment and we will need to reschedule you, and will treat it as a missed appointment. We will make every effort to reschedule you ASAP. Please allow sufficient travel time and take traffic conditions into consideration.
 There are occasions where extenuating circumstances arise and we may be delayed for a brief time. This will not affect the length of your visit. Please accept our apologies for any inconvenience.
 Please allow enough time for your complete visit. If you know you need to leave our office by a specific time, please let us know when you first arrive and we will do our best to accommodate you.

Herbs, Supplements & Prescriptions:
 If for any reason you are unable to take your prescribed items as directed or have questions about their use, please let our office know as soon as possible.
 Unopened bottles in resalable condition can be returned for office credit within 30 days of purchase.
 The following items cannot be returned: refrigerated items, special order items, custom formulas.

Payment:
 Payment is due at the time of your appointment, unless alternate arrangements have been made.
 Accepted methods of payment are: **Cash, Check, American Express**, **Visa, MasterCard, Discover.**
 We require all patients to have a current signed credit card authorization form on file to secure your appointments and fulfill your mail-order prescriptions.

Insurance:
We are currently participating with select plans of Cigna and BlueCross BlueShield insurances, all auto-insurances and all worker's compensation claims. Please check with your insurance if your plan includes acupuncture benefits if administered by a licensed acupuncturist. A medical receipt detailing diagnostic codes and fees can be provided to you for each visit. This receipt can be submitted to your insurance carrier. If you have a healthcare savings account or flexible spending plan, we'll be glad to provide you with documentation for your expenditures that you can submit it for reimbursement.

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Patient Information

Today's date: _____

Name: _____ Birth date: _____Age: _____

Street Address: _____City:_____ State:_____

Home phone: _____ Cell Phone: _____

Work Phone: _____ E-mail Address: _____

Occupation: _____ Employer: _____

Insurance Carrier: _____ Policy number: _____

Marital Status: single married divorced separated in a relationship N/A

Emergency contact:

Name: _____ Phone: _____ Relationship: _____

How did you hear about our center: _____

Referred by _____

May we send a thank you card? Yes No

Primary treating physician: _____ Phone: _____

Other specialist: _____ Phone: _____

Other specialist: _____Phone: _____

Have you ever been treated with acupuncture? Yes No

If yes, condition treated? _____

Credit Card Authorization

We require a current credit card number on file to secure your appointments and for any mailed prescriptions or special orders. We will never charge this number without giving you prior notice.

I, (print name)_____ authorize

Veronica Bolhovitinova, L.Ac, 82 Buck Road, Unit A, Holland, PA 18966 to bill my credit card as listed below:

Name on Credit Card _____

Credit Card Details

Circle one: Visa MasterCard American express Discover

Card # _____

Expiration Date: _____

CVS code (3 digit security code on back of card)**:** _____

Billing Address

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone (include area code)**:** _____

AUTHORIZATION

X_____
Cardholder's signature Today's date

This authorization can be revoked upon your written notice to our office.

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Informed Consent

I hereby request and consent to the performance of acupuncture treatments, other Oriental Medicine and/or Functional/Energetic Medicine procedures by the licensed practitioner listed below. I understand that the treatment may include, but not limited to: acupuncture, acupressure, moxibustion, cupping, heat lamp, Chinese or Western herbal medicine, homeopathy, nutritional testing or kinesiology. I have had an opportunity to discuss with the practitioner named below the nature and purpose of these treatment modalities and other procedures. I understand that results are not guaranteed.

Acupuncture: I have had an opportunity to discuss with a practitioner the nature and purpose of said treatment and/or other procedures. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that may last a few days. **Initial here_____.**

Neuro-Emotional Technique (NET): Emotions have a psychological aspect, however this technology is not psychology or psychiatry. Psychological aspects of emotional health will be referred out to an appropriate health care professional. Additionally, this technology does not deal with the spiritual realm. It does not make claims as to what events may have historically happened in the past. It does not tell people what their psychological plan of action may, must, or should be for the future.. **Initial here_____.**

Nambudripad Allergy Elimination technique (NAET): I understand that once I have been cleared for a sensitivity to an allergen, it is my responsibility to recheck the clearing within one week. I understand that I may still have a reaction to that allergen if it is not cleared and additional treatment sessions may be necessary to clear the allergen completely. **Initial here_____.**

Nutritional Response Testing (NRT): I understand that this technique will test for the nutritional supplements which my body may be craving to reach maximum health benefits from nutrition. I understand that the supplements selected are not a replacement for my regular medications, and that I will not make any changes regarding the prescribed medications without discussing it with my medical doctor. **Initial here_____.**

To present, there may not be formal scientific studies completed for my particular condition now or those conditions that are treated in the future with these technologies. I understand that my return to health is a process of brining my body into harmony with the bodies own ability to heal. **Initial here_____.**

I understand the contents of this consent form; and I have had an opportunity to ask questions about this consent. By signing below I agree to the above named procedures.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
Parent's or Authorized Person's name	Parent's Signature	Date

Practitioner: Veronica Bolhovitinova, L.Ac.

Health History

Name: _____Today's Date: _____

Reason for visit: Please list your 5 major health concerns in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Major hospitalizations, surgeries, illnesses, injuries:

Year	Surgery, illness, injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Height: _____ Weight: _____ BMI: _____

Do you consider yourself: Under-weight Over-weight Just right

Have you experienced unexpected weight gain or weight loss of greater than 10 pounds in the last three months?

Yes No If yes, how much? _____

Do you smoke? Yes No If yes, how much per day? _____ Per week? _____

Do you drink alcohol? Yes No Type: _____ Quantity: _____

Medications & Supplements

Please list any known allergies:

_____

_____

_____

Please list all current medications that you are taking:

Start date:	Item:	Amount:	Frequency:

Please list all current vitamin supplements and herbs that you are taking:

Start date:	Item:	Amount:	Frequency:

The following questions are for female patients only:

Are you pregnant? _____ Any chance you could be pregnant? _____

Describe your menstrual cycles REGULAR IRREGULAR EARLY LATE

_____

Is your menstrual flow NORMAL LIGHT HEAVY WITH CLOTTS ?

Is the blood BRIGHT RED PURPLISH DARK LIGHT in color?

Is your vaginal discharge CLEAR-THIN WHITE or YELLOW-THICK ?

Do you experience PMS? Please describe _____

Number of Pregnancies: _____Number of childbirths _____

Have you had fertility therapy in the past? _____ Present _____

What type of fertility therapy? _____

Type of birth control used in the past _____ Present _____

Do you have problem with conceiving _____ infertility _____

Do you have signs and symptoms of menopause?

Hot Flushes Spontaneous Sweating Weight gain Headaches Vaginal Bleeding

Other symptoms: _____

Please describe any other GYN/ obstetric issues you may have

_____

_____

Reviewed by: _____ Date _____

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Bladder problem
- ❑ Blood pressure: low
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue
- ❑ Carpal tunnel
- ❑ Cholesterol elevated
- ❑ Circulatory problems
- ❑ Cloudy thinking
- ❑ Colitis
- ❑ Constipation
- ❑ Debilitating fatigue
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diarrhea, chronic
- ❑ Diverticulitis
- ❑ Dizziness, chronic
- ❑ Drug addiction
- ❑ Drug use
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastric reflux
- ❑ Genetic disorder
- ❑ Gout
- ❑ Headache: migraine
- ❑ Headaches: stress
- ❑ Heart disease
- ❑ Hypertension
- ❑ Infection, chronic
- ❑ IBS
- ❑ Insomnia, chronic
- ❑ Kidney disease
- ❑ Liver or gallbladder disease (stones)
- ❑ Nausea, chronic
- ❑ Vomiting, chronic
- ❑ Neurological issues
- ❑ Panic attacks
- ❑ Pain, chronic
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ SAD disorder
- ❑ Skin problems
- ❑ Ulcer
- ❑ Urinary tract infctn
- ❑ Varicose veins
- ❑ Other

_____

_____

Family Health History (Parents & Siblings):

- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune disordr
- ❑ Cancer
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Heart disease
- ❑ Obesity
- ❑ Stroke
- ❑ Other

Exercise:

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes durat.
- ❑ Less than 30 min
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Cycle
- ❑ Yoga
- ❑ Other

_____

Nutrition and Diet:

- ❑ Omnivore (animal & vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Processed foods
- ❑ Whole foods
- ❑ Specific food restrictions:
- ❑ Dairy
- ❑ Wheat
- ❑ Eggs
- ❑ Soy
- ❑ All Gluten
- ❑ Other

_____

Food Frequency

How many servings per day?

_____Fruits
_____Vegetables
_____Grains
_____Beans and peas
_____Nuts and seeds
_____Dairy
_____Eggs
_____Meat
_____Poultry
_____Fish

Eating Habits:

- ❑ Skip breakfast
- ❑ Eat three meals/day
- ❑ Eat two meals/day
- ❑ Eat one meal/day
- ❑ Graze (small meals)
- ❑ Eat constantly
- ❑ Eat on the run
- ❑ How many times do you eat out per week?

_____

- ❑ How many alcoholic beverages do you consume in a week?

_____

- ❑ How many caffeinated beverages do you consume per day?

_____

Would You Like To:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Not be dependent on over the counter medications like aspirin, ibuprofen, antihistamine sleeping aids, etc
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flues
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (i.e. cancer, heart disease, etc.)