Welcome!

Before your first appointment, I would like to thank you for the opportunity to work with you as you create a healthier life. I am grateful that you chose Oriental Medicine Specialists. For over a decade we have worked hard to promote and provide quality Holistic healthcare. In this packet you'll find information on my practice and *New Patient Information Forms*. Please print and complete these documents and be sure to bring them to your first appointment.

No matter what your reasons for seeking treatment, the initial consultation is a very important part of Traditional Chinese Medicine. During that visit we will discuss why you've sought treatment, make a comprehensive review your health history and I will answer any questions you might have. Most clients will receive an acupuncture treatment during this first session. It is important to allow the full allotted time for this visit. Also, keep in mind all fees are due at the time of service and my practice only accepts cash, check, Visa, MasterCard or Discover. A detailed list of our fees is included.

Oriental Medicine Specialists is conveniently located near the Willow Lawn Shopping Center at 5500 Monument Avenue in Suite R. Be sure to wear loose, comfortable clothing and eat a light meal 1-2 hours prior to your appointment time. If you won't be able to keep your appointment for any reason please remember to provide at least 1 days notice. Thank you again for choosing Oriental Medicine Specialists. I look forward to working with you!

Sincerely,

R. Keith Bell,
Licensed Acupuncturist

5500 Monument Avenue, Suite R · Richmond, VA 23226
Ph. (804) 358-7071 · www.orientalmedicinespecialists.com · Fax (804) 358-7073

Oriental Medicine Specialists, P.C.

Please Print Clearly

Patient Information

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.	*Legal Last Name*	*First Name*	*Middle In.*
Age	*Date of Birth*	*Place of Birth*	*Social Security No.*

Marital Status ❑ Single ❑ Married ❑ Cohabitating ❑ Separated ❑ Divorced *Sex* ❑ Female ❑ Male

Home Address			*PO Box /Billing Address*		
City	*State*	*Zip Code*	*City*	*State*	*Zip Code*
Home Phone	*Mobile Phone*	*Work Phone*	*Email Address*		
Occupation			*Employer*		*How long?*

Emergency Contact & Release of Information

Persons to whom confidential information may be released.

Full Name	*Relationship*
Address	*Phone*
Full Name	*Relationship*
Address	*Phone*

How did you hear about us?

❑ Advertisement ❑ Web-site

❑ *Family/Friend*

❑ *Other*

❑ *Physician Referral (name)*

Referral - Primary Care Provider

Have you received a diagnostic exam or treatment in the last six months from a licensed doctor of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment? ❑ Yes ❑ No

Physician Name	*Phone*
Other Care / Specialists	*Phone*

Patient Terms of Service Agreement

I certify that all the information I provided on this form is true and accurate to the best of my knowledge. I have received and read a copy of the Office Policies, including the policies concerning *Patient Fees & Payment* and *Appointment Cancelation*. I understand and agree that these policies are reasonable and necessary. I agree to adhere to all policies as well as any future alterations or changes to the Office Policies. I understand that by scheduling an appointment for myself I am agreeing to pay for the time reserved as well as any professional services provided. **I agree to provide Oriental Medicine Specialists, P.C. with 1 business days' notice when canceling a scheduled appointment. I understand that if I cancel an appointment without providing the required notice I will be charged a cancelation fee equal the normal cost of the scheduled appointment. I AGREE TO PAY ALL CANCELATION FEES IN FULL WITHIN 30 DAYS.**

Signature *Date*

Print Name

Oriental Medicine Specialists, P.C.

Patient Name: _____ **Date:** _____

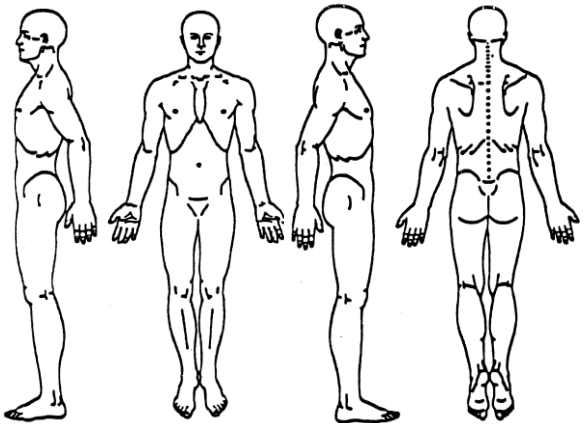
Marital Status ❑ Single ❑ Married ❑ Cohabitating ❑ Separated ❑ Divorced **Children?** _____

Age _____ **Height** _____ **Weight** _____ How long this weight? _____

What is your primary reason for this visit? (Including: when & where it began, severity, frequency of symptoms)

What diagnosis/explanations have you received? **(if any)**

Please mark areas most affected this condition.



How does this condition affect your daily life?
Triggers? Makes worse? Makes better?

What types of treatment have received/tried and how effective were they? **Treatment • Date(s) • Practitioner • Effect**

Physician & Health Care Providers - Please list your primary care provider & any others you are currently being treated by.

Provider Name	Specialty – Treatment	Phone

Please list any other major health problems you would like treatment for.

Have you ever been treated with Traditional Chinese Medicine, acupuncture or Chinese herbs? ❑ NO ❑ YES

(If yes: When, Where, Result)

How would you rate your overall health?	*Very poor*	1	2	3	4	5	6	7	8	9	10	*Excellent*
How would you rate your energy level?	*Very poor*	1	2	3	4	5	6	7	8	9	10	*Excellent*

At what point in your life did you feel the best?

Oriental Medicine Specialists, PC

Family Health History Mark all that apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age - if still living									
Age at death									
Heart Attack / Disease									
Stroke									
Breast Cancer									
Colon Cancer									
Prostate Cancer									
Skin Cancer									
Uterine or Ovarian Cancer									
Cancer, Other									
ADD/ADHD									
ALS: other Motor Neuron Diseases									
Alzheimer's / Dementia									
Blood disorders: Anemia/clotting problems									
Anxiety / Depression									
Arthritis: Rheumatoid / Psoriatic									
Osteoarthritis									
Asthma / Emphysema									
Autism									
Autoimmune Diseases									
Bladder / Kidney disease									
Celiac disease									
Obesity - Diabetes									
Eczema / Psoriasis									
Environmental Sensitivities									
Epilepsy									
Glaucoma									
High Blood Pressure									
High Cholesterol									
Sleep Apnea/ Insomnia/ Other									
Irritable Bowel Syndrome									
Multiple Sclerosis									
Osteoporosis									
Parkinson's									
Psychiatric: Bipolar, Schizophrenia, Etc.									
Smoking addiction									
Substance abuse									
Ulcers									

Oriental Medicine Specialists, P.C.

Check any illnesses or conditions you have or had in the past

- ❑ Allergies
- ❑ Antibiotic uses
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Injury
- ❑ Bleeding tendencies
- ❑ Broken Bones or Fractures
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chicken pox
- ❑ Chronic Fatigue
- ❑ Chlamydia
- ❑ Crohn's Disease Ulcerative Colitis
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy convulsions/seizures
- ❑ Erectile Dysfunction
- ❑ Gall Stones
- ❑ Glaucoma
- ❑ Gonorrhea
- ❑ Gout
- ❑ Head injury
- ❑ Heart Attack, Angina
- ❑ Heart Failure
- ❑ Heart trouble, other
- ❑ Hepatitis
- ❑ Herpes
- ❑ High blood fats cholesterol, triglycerides
- ❑ High blood pressure
- ❑ HIV – AIDS
- ❑ Irritable bowel chronic diarrhea
- ❑ Jaundice
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Male Infertility
- ❑ Meningitis
- ❑ Mental Illness
- ❑ Mononucleosis
- ❑ Multiple sclerosis
- ❑ Mumps or Measles
- ❑ Neck injury
- ❑ Nervous disorder
- ❑ Parasites
- ❑ Premature ejaculation
- ❑ Prostate Cancer
- ❑ Prostate infection
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic fever
- ❑ Sinusitis
- ❑ Seizures
- ❑ Sleep Apnea
- ❑ Sores on your genitals
- ❑ Stroke
- ❑ Syphilis
- ❑ Testicle: Pain, swelling or Trauma
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose veins
- ❑ Vein trouble
- ❑ Whooping Cough
- ❑ Yeast Infection(s)
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____

Immunizations

❑ Small pox ❑ Tetanus ❑ Diphtheria ❑ Pertussis ❑ Polio ❑ Mumps ❑ Measles
❑ Rubella ❑ Cholera ❑ Typhoid ❑ Influenza ❑ Other _____

Hospitalizations or surgeries: in & out-patient services ***Attach list at end if necessary**

Date	Description	Outcome

List all medications (prescription & over-the-counter) you are currently taking. *Attach list at end if necessary

Medication	Dosage	Date Started	Date Stopped
Hormone regulating medications such as Propecia®			

Recent Lab Tests	Date	Result

Sleep			
Time to sleep:	Time to rise:	Hours:	Do you have trouble falling asleep? ❑NO ❑YES
Do you wake up in the night? ❑ NO ❑ YES -		Why? What time?	
Are you rested in the morning? ❑ NO ❑ YES		*Other comments:*	

	❑ YES ❑ NO	Are you sexually active?
	❑ YES ❑ NO	Do you feel satisfied by your sexual experiences?
	❑ YES ❑ NO	Difficulty experiencing orgasm
	❑ YES ❑ NO	Have you had more than one sex partner in the past 6 months?

Oriental Medicine Specialists, P.C.

Nutrition History

How good do you feel your nutrition is?

Do you follow a special Diet?

❒ Diabetic ❒ Low carb ❒ Ovo-lacto ❒ Vegetarian ❒ Blood type diet
❒ Dairy restricted ❒ Gluten Free ❒ Paleo ❒ Vegan ❒ Other

Usual Breakfast		Usual Lunch		Usual Dinner	
❑ None	❑ Sweet roll	❑ None	❑ Pizza	❑ None	❑ Poultry
❑ Bacon/Sausage	❑ Sweetener	❑ Butter	❑ Potato chips	❑ Beans (legumes)	❑ Red meat
❑ Bagel	❑ Tea	❑ Coffee	❑ Salad	❑ Brown rice	❑ Rice
❑ Butter	❑ Toast	❑ Eat in cafeteria	❑ Salad dressing	❑ Butter	❑ Salad
❑ Cereal	❑ Water	❑ Eat in restaurant	❑ Soda	❑ Carrots	❑ Salad dressing
❑ Coffee	❑ Wheat bran	❑ Fish sandwich	❑ Soup	❑ Coffee	❑ Soda
❑ Donut	❑ Yogurt	❑ Fried foods	❑ Sugar	❑ Fish	❑ Sugar
❑ Eggs	❑ Oat meal	❑ Hamburger	❑ Sweetener	❑ Green vegetables	❑ Sweetener
❑ Fruit	❑ Milk protein shake	❑ Hot dogs	❑ Tea	❑ Juice	❑ Tea
❑ Juice	❑ Slim fast	❑ Juice	❑ Tomato	❑ Margarine	❑ Vinegar
❑ Margarine	❑ Carnation shake	❑ Leftovers	❑ Vegetables	❑ Milk	❑ Water
❑ Milk	❑ Soy protein	❑ Lettuce	❑ Water	❑ Pasta	❑ White rice
❑ Oat bran	❑ Whey protein	❑ Margarine	❑ Yogurt	❑ Potato	❑ Yellow vegetables
❑ Sugar	❑ Rice protein	❑ Mayo	❑ Slim fast	❑ Other:	
❑ Other		❑ Meat sandwich	❑ Carnation shake		
		❑ Milk	❑ Protein shake		
		❑ Other			

Water intake per day?					
Typical snacks?					
Worst foods in your diet?					
Foods you crave? *Sweet / salty / etc.*					
Alcohol	x week	Coffee	x week	Artificial Sweeteners	x week
Soda	x week	Smoking	x week	Recreational Drugs	x week

Dietary Supplements	Dosage	Purpose	Length of use

Type of Exercises You Do	Times per week

Elimination

Bowel Consistency ❑ Hard ❑ Loose ❑ Well-formed ❑ Float ❑ Sink ❑ Blood ❑ Mucus ❑ Undigested food

Bowel movements feel complete? ❑ YES ❑ NO Painful bowel movements? ❑ YES ❑ NO

Urination ❒ Frequent Infections ❒ Burning ❒ Urgent ❒ Retention ❒ Scanty ❒ Profuse ❒ Dribbling ❒ At Night

Oriental Medicine Specialists, P.C.

Body System Review

Please circle what applies to you. 1 - Never 2 - Rarely 3 - Occasionally 4 - Frequently 5 - Always

1	2	3	4	5	low appetite	1	2	3	4	5	ravenous appetite
1	2	3	4	5	loose stools	1	2	3	4	5	heartburn/acid reflux
1	2	3	4	5	mouth sores	1	2	3	4	5	fatigue after eating
1	2	3	4	5	gas/bloating after food	1	2	3	4	5	bruise easily
1	2	3	4	5	bleeding/swollen gums	1	2	3	4	5	thirst
1	2	3	4	5	organ prolapsed (diagnosed)	1	2	3	4	5	belching or vomiting
1	2	3	4	5	allergies	1	2	3	4	5	catch colds easily
1	2	3	4	5	asthma	1	2	3	4	5	shortness of breath
1	2	3	4	5	general weakness	1	2	3	4	5	cough
1	2	3	4	5	dry nose/mouth/skin/throat	1	2	3	4	5	nasal discharge
1	2	3	4	5	feel worse after exercise	1	2	3	4	5	sinus congestion
1	2	3	4	5	sore, cold or weak knees	1	2	3	4	5	feel cold, in core
1	2	3	4	5	low back pain	1	2	3	4	5	cold hands &/or feet
1	2	3	4	5	frequent urination	1	2	3	4	5	urinary incontinence
1	2	3	4	5	early morning diarrhea	1	2	3	4	5	hearing loss
1	2	3	4	5	impaired memory	1	2	3	4	5	edema
Normal		*High*		*Low*	libido / sex drive			❑ YES	❑ NO		hair loss
1	2	3	4	5	muscle spasms/twitches	1	2	3	4	5	irritable
1	2	3	4	5	feel better after exercise	1	2	3	4	5	numb extremities
1	2	3	4	5	tightness in chest	1	2	3	4	5	dry eyes
1	2	3	4	5	alternating diarrhea & constipation	1	2	3	4	5	ear ringing
1	2	3	4	5	symptoms worse with stress	1	2	3	4	5	anger easily
1	2	3	4	5	neck/shoulder tension	1	2	3	4	5	red eyes
1	2	3	4	5	feel heart beating	1	2	3	4	5	chest pain
1	2	3	4	5	insomnia	1	2	3	4	5	disturbing dreams
1	2	3	4	5	sores on tip of tongue	1	2	3	4	5	headaches
1	2	3	4	5	chest pain traveling to shoulders	1	2	3	4	5	restlessness
Normal		*High*		*Low*	overall body temperature	1	2	3	4	5	anxiety
Normal		*High*		*Low*	overall energy level	1	2	3	4	5	panic attacks
1	2	3	4	5	see floaters in eyes	1	2	3	4	5	foggy thinking
1	2	3	4	5	heat in palms or soles	1	2	3	4	5	dizzy upon standing
1	2	3	4	5	feeling of heaviness	1	2	3	4	5	nausea
1	2	3	4	5	afternoon fever	1	2	3	4	5	night sweats
1	2	3	4	5	enlarged lymph nodes	1	2	3	4	5	cloudy urine
1	2	3	4	5	face flushes						

Comments or additional information for your acupuncturist.

Oriental Medicine Specialists, P.C.

Stress Management & Lifestyle

Current level of stress you experience?	*Very Low*	1	2	3	4	5	6	7	8	9	10	*High*

Major causes of stress, such as recent changes in job, home life, finances:

Have you experiences any positive life changes recently?

How would you describe your health and emotional state as a child?

What is your opinion of yourself?	*Negative*	1	2	3	4	5	6	7	8	9	10	*Positive*

How do you feel about your work environment?	*Negative*	1	2	3	4	5	6	7	8	9	10	*Positive*

How do you feel about your home environment?	*Negative*	1	2	3	4	5	6	7	8	9	10	*Positive*

Activities that give you a sense of pleasure & accomplishment?	***What is the most negative emotion you experience?*** *When & where?*

In order to improve your health, how ready & willing are you to...

	Not Willing					*Very Willing*
Significantly modify your diet	1	2	3	4	5	
Take nutritional supplements each day	1	2	3	4	5	
Keep a record of everything you eat each day	1	2	3	4	5	
Modify your lifestyle (e.g. work demands, sleep habits)	1	2	3	4	5	
Practice relaxation techniques	1	2	3	4	5	
Engage in regular exercise	1	2	3	4	5	
Have periodic lab tests to assess progress	1	2	3	4	5	

I certify that I have answered all questions honestly, to the best of my ability and that the information I have provided is accurate.

Signature *Date*

ORIENTAL MEDICINE SPECIALISTS, P.C.
Keith Bell, Licensed Acupuncturist

AUTHORIZATION TO DISCLOSE MEDICAL/HEALTH INFORMATION

Patient Name _____ **Today's Date** _____

Date of Birth _____ **Social Security No.** _____

1. I authorize the use &/or disclosure of the above named individual's health information as described below:

2. The following individual &/or organization is authorized to make the disclosure:
   Physician/Provider _____ **Phone** _____
   Address _____
   Street *City* *State* *Zip*

3. **THE PURPOSE FOR THIS RELEASE:** You are hereby authorized to furnish and release to and used by **Oriental Medicine Specialists, P.C. of 5500 Monument Avenue, Suite R, Richmond, VA 23226** all information from my medical, psychological, &/or other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

   In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:
   - ❑Yes ❑No Alcohol or Drug Abuse
   - ❑Yes ❑No Communicable disease related information, including AIDS or ARC diagnosis &/or HIT or HTLA-III test results or treatment
   - ❑Yes ❑No Genetic Testing

   Please note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

4. I understand that I have the right to revoke this authorization at any time by presenting Oriental Medicine Specialists, P.C with a written revocation. I understand revocation will not apply to information that has already been released in good faith in response to this authorization. I understand a copy of this authorization shall be as valid as the original.

5. I understand that authorizing the disclosure of this health information is voluntary.

_____ _____
Patient Signature **Date**

Oriental Medicine Specialists, P.C.

Keith Bell, Licensed Acupuncturist

This notice describes how health and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses & Disclosures for Treatment, Payment & Health Care Operations

We may use or disclose your protected health information (PHI) for treatment, payment, or health care operations purposed with your consent. To help clarify these terms here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would when we consult with another health care provider, such as your family physician or a specializing physician.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities, business-related matter such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities with our office/clinic/practice group, such as releasing, transferring or providing access to information about to other parties.
- "Disclosure" applies to activities outside our office/clinic/practice group/etc, such as releasing, transferring or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and healthcare operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your medical records.

You may revoke all such authorization at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses & Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services.
- **Adult and Domestic Abuse:** If we have reason to suspect that an adult is abused, neglected or exploited, we are required by law to immediately make a report and provide relevant information to the Virginia Department of Welfare and Social Services.
- **Health Oversight:** The Virginia Board of Medicine has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legal representative, or a subpoena (of which you have been served, along with the proper notice required by state law). However, if you move to quash the subpoena, we are required to place said records in a sealed envelope and provide them to the clerk of court of the appropriate jurisdiction so that the court can determine whether the records should be released. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we are engaged in our professional duties and you communicate to us a specific and immediate threat to cause serious bodily injury or death, to an identified or to an unidentified person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we must take steps to protect third parties. These precautions may include (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18; or (2) notifying a law enforcement officer.
- **Worker's Compensation:** If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant health information to you, your employer, the insurer, or a certified rehabilitation provider.

IV. Patients' Rights & Provider's Duties

Patient's Rights

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communication by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (Example: you may request your bill be sent to an alternate address.)
- Right to Inspect and Copy – You have the right to inspect and obtain a copy (or both) of PHI and bill records used to make decisions about you for as long as the PHI is maintained in the record (service charges and copy fees may apply.)
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request.
- Right to Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On request, we will discuss with you the detail of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice form our office/clinic, even if you have agreed to receive the notice electronically.

Health Provider's Duties

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy policies and practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise my policies and procedures, we will advise you of this change by posting that change in the waiting room.

V. Questions and Complaints

If you have questions about this notice or other concerns about your privacy rights, or if you have a complaint please contact Joshua Sessions at Oriental Medicine Specialists, P.C. 5700 West Grace Street, Suite 106, Richmond, VA, 23226. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 1, 2007. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by posting this information in the waiting room of the office.

Treatment Guidelines

- Due to patients with sensitivities to smells, please refrain from wearing perfume, aftershave, or any other products that are heavily scented to your appointment.
- Please avoid chewing gum or eating candy which would discolor the mouth and tongue before your treatment.
- Smoking is not advisable within 1 hour before your treatment.
- There is no smoking in our office; please do not wear clothes that are heavily scented with smoke.
- Please do not eat a large meal immediately before your treatment.
- Please do not engage in heavy exercise, sexual activity or consume alcoholic beverages or recreational drugs within 6 hours after your treatment. These activities will interfere with the effectiveness of that treatment.
- Please refrain from extremely hot baths, showers, Jacuzzi or sauna for 6 hours after your treatment.
- Plan your activities so that after your treatment you can get some rest, or at least not have to be working at top performance. This is especially important for the first few visits.
- Continue to take any prescription medicines as directed by your doctor.
- Acupuncture is an excellent adjunct therapy to massage, physical therapy, and chiropractic adjustments, if these treatments are on the same day as your acupuncture please be sure all practitioners are aware of this so that treatment can be adjusted to enhance your therapy.
- Remember to keep good mental or written notes of what your response is to the treatment. This is important so that the follow- up treatments can be designed to best help you and your problem.
- Drink plenty of water after your treatment.

5500 Monument Avenue, Suite R · Richmond, VA 23226
Ph. 804-358-7071 · www.OrientalMedicineSpecialists.com · Fax 804-358-7073