Washington State Department of Labor & Industries

**Oswestry Disability Index[1]**

L&I Claim Number:_____ Date:

**Section A: To be completed by patient**

Age:_____ Date:_____Occupation:_____ Number of days of back pain (this episode): _____

**Section B: To be completed by patient**

Please answer every question by placing a mark on the line that best describes your condition today. **Please mark only the box that most closely describes your current condition.**

**Section 1-Pain Intensity**

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

**Section 2-Personal Care (Washing, Dressing, etc.)**

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of personal care.
- ☐ I do not get dressed, I wash with difficulty, and I stay in bed.

**Section 3-Lifting**

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain
- ☐ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

**Section 4-Walking**

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

**Section 5-Sitting**

- ☐ I can sit in any chair as long as I like
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

**Section 6-Standing**

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but my pain increases with time.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 1/2 hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

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L&I Claim Number:_____ Date:

**Section 7-Sleeping**

- ☐ My sleep is not disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of my pain, my sleep is only 3/4 of my normal amount.
- ☐ Because of my pain, my sleep is only 1/2 of my normal amount.
- ☐ Because of my pain, my sleep is only 1/4 of my normal amount.
- ☐ Pain prevents me from sleeping at all.

**Section 8-Social Life**

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain has no significant effect on my social life, but prevents me from participating in more energetic activities (e.g. sports, dancing)
- ☐ Pain has restricted my social life and prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

**Section 9-Traveling**

- ☐ I get no increased pain when traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get increased pain while traveling, but it does not cause me to seek alternative forms of travel.
- ☐ I get increased pain while traveling, which causes me to seek alternative forms of travel.
- ☐ My pain restricts all forms of travel except that which is done while I am lying down.
- ☐ My pain restricts all forms of travel.

**Section 10-Sex Life (If applicable)**

- ☐ My sex life is normal and does not increase my pain.
- ☐ My sex life is normal, but it increases my level of pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

**Section C: To be completed by provider**

Score of All Sections:_____ Percent Disability:_____

Treatment Visit (Check one): Initial Treatment ☐ Middle/Fifth Treatment ☐ Final Treatment* ☐

*If "Final Treatment" is checked, list total number of acupuncture treatments patient received, and reason for discharge:

[1] Fairbank, Jeremy CT, and Paul B. Pynsent. "The Oswestry disability index." Spine 25.22 (2000): 2940-2953.

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L&I Claim Number:_____ Date:

Treatment Visit (Check one): Initial Treatment ☐ Middle Treatment ☐ Final Treatment* ☐

**If "Final Treatment" is checked, list total number of acupuncture treatments patient received*:_____

# *Please complete this form at initial, middle, and final treatments*

## 2-item Graded Chronic Pain Scale (2-item GCPS)*

***Please select only one number for each question**

| Graded chronic pain scale: a two-item tool to assess pain intensity and pain interference | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **In the last month**, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be." [*That is, your usual pain **at times you were in pain**.*] | | | | | | | | | | |
| **No pain** | | | | | | | | | | **Pain as bad as could be** |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **In the last month**, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities." | | | | | | | | | | |
| **No interference** | | | | | | | | | | **Unable to carry on any activities** |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Purpose**: The two-item version of the Graded Chronic Pain Scale is intended for brief and simple assessment of pain severity in primary care settings. Based on prior research, ***the interpretation of scores on these items is as follows***:

| Pain Rating Item Scoring Interpretation | Mild | Moderate | Severe |
|---|---|---|---|
| Average/Usual Pain Intensity | 1–4 | 5–6 | 7–10 |
| Pain-related interference with activities | 1–3 | 4–6 | 7–10 |

Although pain intensity and pain-related interference with activities are highly correlated and tend to change together, it is recommended that change over time be tracked for pain intensity and pain-related interference with activities separately when using these two items.

For an individual patient, a reduction in pain intensity and improvement in pain-related interference with activities of two points is considered moderate but clinically significant improvement.

Similar pain ratings have been widely used in the Brief Pain Inventory, the Multidimensional Pain Inventory, and the Pain Severity Scale of the SF-12.

There is extensive research on the reliability, validity and responsiveness to change of these pain severity ratings, which is summarized in the following reference:

Von Korff, M., *Assessment of chronic pain in epidemiological and health services research: Empirical bases and new directions*, in *Handbook of Pain Assessment Third Edition*, D.C. Turk and R. Melzack, Editors. 2011, Guilford Press: New York. p. 455-473.

MERULLI ACUPUNCTURE & WELLNESS
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Name _____ Email _____ Phone _____
Address _____ City/State/Zip _____
Age _____ Birthdate _____ Height _____ Weight _____ Gender ____ Blood Type _____
Occupation _____ Employer _____
Physician _____ Phone _____
Emergency Contact & Phone _____ Relationship _____
How did you hear about my practice? Website/Referral/Friend/other _____

**PAYMENT INFORMATION**

Credit Card # _____ Exp. Date _____ CCV _____

*Being the authorized cardholder, by signing I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize Merulli Acupuncture & Wellness to charge my credit card for the services provided. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed.* ***Please initial _____***

Insurance Plan _____ Patient ID _____ Group Number _____
SSN # _____ Copay Amount _____ Deductible Amount _____

**TREATMENT GOALS**

What are your health goals?

**HEALTH HISTORY**

Have you been treated with Acupuncture Medicine before? Y/N

Have you ever had a work related, L&I, or automobile accident injury? Y/N Please list dates _____
Please list symptoms and dates they began:

To what extent do they interfere with your daily activities?

Have you been given a diagnosis?

What kinds of treatment have you tried?

Surgeries medical and cosmetic please list all, and dates:

Significant Trauma-List auto accidents, falls, emotional stress, etc.:

Allergies- please list drugs, chemicals, and food:

Medicines taken within the last two months including vitamins, drugs, herbs:

Occupational stress list chemical, physical, psychological:

Do you have an exercise program? Please describe:

List any dietary restrictions past or present:

What is your average daily diet?

Do you have a spiritual practice you'd like me to be aware of?

How many packs of cigarettes do you smoke per day?

How much coffee, tea or cola do you drink per day?

How much alcohol do you consume per day?

How much water do you drink per day?

Is there anything I need to be aware of that I haven't asked?

**FAMILY HISTORY**

Please circle and note if condition applies to you or family member:

| | | | | |
|---|---|---|---|---|
| Asthma | Diabetes | Stroke | Heart Disease | High Blood Pressure |
| Thyroid Disease | Cancer | Seizures | Other | |

**Please check any symptoms you've had in the lasts 3 months.**

**GENERAL**
- ❑ Chills
- ❑ Fever
- ❑ Sweat easily
- ❑ Night sweats
- ❑ Bleed or bruise easily
- ❑ Peculiar smells or tastes
- ❑ Strong thirst (cold or hot)
- ❑ Thirst, no desire to drink
- ❑ Fatigue
- ❑ Edema
- ❑ Poor sleep
- ❑ Tremors
- ❑ Poor balance
- ❑ Cravings
- ❑ Change in appetite
- ❑ Weight gain/loss

**RESPIRATORY**
- ❑ Cough
- ❑ Asthma/wheezing
- ❑ Pain with a deep breath
- ❑ Phlegm production
- ❑ Coughing blood
- ❑ Pneumonia or Bronchitis

**CARDIOVASCULAR**
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Stroke
- ❑ Chest discomfort/pain
- ❑ Heart palpitations
- ❑ Cold hands or feet
- ❑ Swelling of hands/feet
- ❑ Blood clots or DVT
- ❑ Fainting
- ❑ Pacemaker
- ❑ Shortness of breath
- ❑ Unable to lie down
- ❑ Varicose or spider veins

**SKIN AND HAIR**
- ❑ Rashes
- ❑ Itching
- ❑ Change in hair or skin
- ❑ Eczema
- ❑ Oozing skin lesions
- ❑ Hives
- ❑ Acne
- ❑ Rosacea
- ❑ Recent moles
- ❑ Hair loss

**EYES, EARS, NOSE THROAT**
- ❑ Dizziness
- ❑ Poor vision
- ❑ Night blindness
- ❑ Blurry vision
- ❑ Spots in front of eyes
- ❑ Eye pain/dryness
- ❑ Excessive tears
- ❑ Discharge from ear
- ❑ Nose bleeds
- ❑ Sinus congestion/drainage
- ❑ Grinding teeth
- ❑ Tooth problems
- ❑ Jaw clicks
- ❑ Concussions
- ❑ Recurrent sore throats
- ❑ Snoring

**URINARY**
- ❑ Painful urination
- ❑ Urgency to urinate
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Decrease in flow
- ❑ Peculiar color/odor
- ❑ Incontinence
- ❑ Dribbling
- ❑ Kidney stones
- ❑ Impotency
- ❑ Change of sexual drive
- ❑ Wake up to urinate

**GYNECOLOGY**
- ❑ Length of cycle _____
- ❑ # Bleeding days _____
- ❑ Heavy periods
- ❑ Light periods
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Birth control
- ❑ Miscarriages
- ❑ Menopause
- ❑ Breast lumps
- ❑ PMS
- ❑ Children

**GASTROINTESTINAL**
- ❑ Bad breath
- ❑ Difficulty swallowing
- ❑ Ulcers
- ❑ Appetite change
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn
- ❑ Belching
- ❑ Indigestion
- ❑ Diarrhea
- ❑ Constipation
- ❑ Laxative use
- ❑ Blood in stools
- ❑ Abdominal pain or cramps
- ❑ Gas or Bloating
- ❑ Hemorrhoids

**MUSCULOSKELETAL**
- ❑ Migraines
- ❑ Headaches
- ❑ Facial pain
- ❑ Neck pain
- ❑ Jaw pain
- ❑ Shoulder pain
- ❑ Back pain
- ❑ Elbow pain
- ❑ Spinal pain
- ❑ Hand/wrist pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Muscle pain
- ❑ Muscle weakness
- ❑ Joint pain

**NEUROLOGICAL**
- ❑ Seizures
- ❑ Numbness
- ❑ Weakness
- ❑ Loss of balance
- ❑ Vertigo
- ❑ Concussion

**EMOTION/PSYCHOLOGICAL**
- ❑ Emotional outbursts
- ❑ Sleep disorder
- ❑ Depression
- ❑ Focus issues
- ❑ Susceptible to stress
- ❑ Poor memory
- ❑ Anxiety
- ❑ Substance abuse
- ❑ Suicide attempts
- ❑ Treatment for emotional issues

**PATIENT FINANCIAL AGREEMENT**

Payment is due at time of service unless other arrangements have been made in advance.

**CANCELLATION POLICY AND CHARGE**

Please provide a minimum of 24 hours notice to cancel or change your appointment time.

Please initial _____ I acknowledge the full rate for services booked will be charged for no-shows and cancellations with less than 24 hours notice.

**PAYMENT TERMS**

- Payment for visit, copay and supplies is due at time of service and can be made by cash, check, or credit/debit card.
- Interest accrues at 1% monthly/12% annually on unpaid balances with a $10 monthly statement fee.
- A $40 NSF fee is charged on all returned checks.
- This clinic participates in several insurance plans. If I have insurance, I understand that:
    - I am responsible for understanding my medical benefits.
    - It's my responsibility to contact my insurance plan regarding provider participation, copays, deductibles and referral requirements.
    - I am responsible to pay my copay at the time of service. Copays and deductibles are a contract responsibility between patient and insurance company and are non-negotiable.
    - I am fully responsible for the total payment of all procedures performed in this office, including any procedure that is not a benefit of my medical insurance.
    - Merulli Acupuncture & Wellness bills insurance for acupuncture only, and that all other services are not covered or billable to insurance.
    - Insurance companies do not reimburse for no-shows.
    - I am responsible for non-payment by my insurance company. Accounts unpaid by my insurance company greater than 60 days will be billed to me. Outstanding balances greater than 90 days will be turned over to a collection agency unless prior arrangements have been made in writing.

I, _____ agree to the financial policies of Merulli Acupuncture & Wellness. In the case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account.

I, the undersigned, have read, understand, and accept the information and conditions specified in this document.

Patient Signature _____ Print Name _____ Date _____

**CONSENT TO TREATMENT**

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, acupoint injection, moxibustion, cupping, gua sha, electrical stimulation, herbal therapy, massage, Qi Gong, yoga, laserpuncture, sonopuncture, and nutritional counseling. I understand that these modalities are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses taken without my practitioner's recommendation may be toxic, and some are inappropriate during pregnancy. Some possible side effects of herbs and supplements are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it is necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise their judgment in my best interest during the course of treatment, based upon the known facts.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

Patient Signature _____ Date _____

**COMMUNICATION BY EMAIL, TEXT MESSAGE, AND OTHER NON-SECURE MEANS**

It may become useful during the course of treatment to communicate by email, text message (e.g. “SMS”) or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with your provider, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:
People in your home or other environments who can access your phone, computer, or other devices.
Your employer, if you use your work email to communicate with Merulli Acupuncture & Wellness.
Third parties on the Internet such as server administrators and others who monitor Internet traffic.
If there are people in your life that you don’t want accessing these communications, please talk with us about ways to keep your communications safe and confidential.

**CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS**

I consent to allow Desiree Merulli, L.Ac., EAMP, RYT, to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I understand that I may terminate this consent anytime.

Patient Signature _____ Date _____

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

This notice summarizes your health data use and sharing and how you can get access to this data.

How we may use and share health data about you:

- Treatment - To give you medical treatment or other types of health services.
- Payment - To bill you or a third party for payment for services provided to you.
- Health Care Operations - For our own operations such as quality control, compliance, audit, etc.

Disclosures where we do not have to give you a chance to agree or object:

- As required by federal, state, or local law
- If child abuse or neglect is suspected
- Public health risks (for public health activities to prevent and control spread of disease)
- Lawsuits and disputes (in response to a court or administrative order)
- Law enforcement (to help law enforcement officials respond to criminal activities)
- Coroners, medical examiners and funeral directors
- Organ or tissue donation facilities if you are an organ donor
- To avert a threat to an individual or to public health safety

Disclosures where we have to give you a chance to agree or object:

- Patient directories - You can decide what health data, if any, listed in patient directories.

- Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

Other uses of health data not covered by this notice or the laws that apply to us will be made only with your written consent.

You have the following rights relating to the health data we keep about you:

- Right to inspect your health record and to receive a copy of your health record upon request
- Right to amend information in your health record you believe is inaccurate or incomplete
- Right to know to whom we have disclosed your health information
- Right to ask for limits on the health information data we give out about you
- Right to receive communication from us about your health information in alternate ways
- Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Patient Signature _____ Birthdate _____ Date _____

**NOTIFICATION OF QUALIFICATIONS & EAST ASIAN MEDICINE PRACTITIONER SCOPE OF PRACTICE**

Desiree Merulli, BS. MS, L.Ac., EAMP, RYT  WA State License AC00001810

East Asian medicine is a health care service using East Asian medicine diagnosis & treatment to promote health & treat organic or functional disorders.  Washington State's East Asian Medicine Practitioner scope of practice includes the following:
Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points & meridians
Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points & meridians
Moxibustion
Acupressure
Cupping
Dermal friction technique
Infra-red
Sonopuncture
Laserpuncture
Point injection therapy/acupoint injection (aquapuncture)
Dietary advice & health education based on East Asian medical theory, including the recommendation & sale of herbs, vitamins, minerals, & dietary & nutritional supplements
Breathing, relaxation, & East Asian exercise techniques
Qi Gong
East Asian massage & Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, & stretching of the body & does not include spinal manipulation
Superficial heat & cold therapies

Side effects may include, but are not limited to pain following treatment, minor bruising, infection, needle sickness, broken needle.

The patient must inform the East Asian medicine practitioner if the patient has a severe bleeding disorder or pacemaker prior to any treatment.

Patient Signature _____ Date _____