Bartlett Acupuncture & Herbal Medicine

7 Oak Hill Terrace Suite 105 207 219-0848 Scarborough, ME 04074

Integrative Health History

Name_____Date_____E-mail_____
Phones: _____ (hm) _____ (wk) _____ (cell)
Street Address_____City/State/Zip_____
Emergency Contact _____ Phone_____
How did you hear about us? _____
Who may we thank for referring you? _____ E-Mail_____
Street Address_____ City/State/Zip_____

What are your primary health concerns? _____
_____
_____

Please list any secondary health concerns you may have:
_____ _____

_____ _____

Who is your current Healthcare Provider? _____
Address_____
Phone_____ Date of Last Physical_____

What is your:
Height _____ Blood Pressure _____ Age_____
Weight _____ Weight, 1 yr ago _____ Date of Birth_____

Personal Health History: Check the appropriate box if you have experienced any of the following:

- ☐ Adverse reaction to medical treatment
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis or rheumatism
- ☐ Artificial heart, valve or joints
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Cancer or Tumor
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Eye Disorder
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis, jaundice or Liver disorder
- ☐ Herpes
- ☐ High Blood pressure
- ☐ Immune Disorder
- ☐ Kidney Disorder
- ☐ Low Blood Pressure
- ☐ Musculo-skeletal Disorder
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Respiratory Disorder
- ☐ Rheumatic Fever
- ☐ Sciatica
- ☐ Seizures/Epilepsy
- ☐ Skin Disorders
- ☐ Special Diet
- ☐ Stomach or Intestinal Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Transfusion (before March 1985)
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Tract Disorder
- ☐ Venereal Disease
- ☐ Other: _____

Is there anything we should know about your medical history?

_____

_____

Major Hospitalizations: If you have even been hospitalized for any serious medical illness or surgery, write in your most recent hospitalizations below. *Check this box ☐ if you have had more than three such hospitalizations.* (Do not include normal pregnancies).

1st Hospitalization_____
Year Operation/Illness Hospital/City/State

2nd Hospitalization _____
Year Operation/Illness Hospital/City/State

3rd Hospitalization _____
Year Operation/Illness Hospital/City/State

FAMILY HISTORY: Complete for each family member. Place X in box indicating any illnesses they ever had								
	Mother	***Father***	***Grdmother***	***Grdfather***	***Sister***	***Brother***	***Spouse***	***Children***
Allergies								
Anemia/Blood Dis								
Cancer or Tumors								
Chemical Dependency								
Diabetes								
Heart Disease								
High Blood Pressure								
Kidney or Bladder Dis								
Seizures / Epilepsy								
Stomach-Intestinal Dis								
Stroke								
Tuberculosis								
Other								
Age at Death								

Medications & Supplements: Check the box next to any of the following that you are now taking.

- ☐ Antacids
- ☐ Aspirin
- ☐ Cold tablets
- ☐ Diet pills
- ☐ Diuretics
- ☐ Tylenol
- ☐ Viagra
- ☐ Allergy medication
- ☐ Ibuprofen/Advil
- ☐ Laxatives
- ☐ Oral Contraceptives
- ☐ Blood pressure medication
- ☐ Prescription pain medication
- ☐ DHEA/ melatonin/ Beta HCG
- ☐ Sleeping pills
- ☐ Tranquilizers
- ☐ Herbs
- ☐ Vitamins
- ☐ Antidepressants
- ☐ Hormone replacement therapy
- ☐ Cumadin/ Plavix / anticoagulants

Please list any medications that you are currently taking that are not listed above, indicating purpose:

_____ _____ _____

_____ _____ _____

Please list any medication allergies you have:

_____ _____ _____

_____ _____ _____

Habits: Please mark any of the habits listed below which apply to you.

Use of tobacco: □ Yes □ No If yes, # of cigarettes/day _____ age started_____ Year Quit _____

Use of alcohol: □ Yes □ No If yes, # of drinks per week _____ age started_____ Year Quit _____

Use of Caffeine: □ Yes □ No # colas / day_____ # coffee / day _____ # tea / day_____

Previous Pregnancies: Please fill in completely.

	Year	Length of Preg	Labor Hours	Type of Delivery	Sex	Weight	Name
1.							

Complications_____

2._____

Complications_____

3._____

Complications_____

Tell us about your lifestyle:

What sort of diet do you have? (Check one) □ Standard American □ Weight loss type
□ Fast/Quick Prep Diet □ Vegetarian □ Vegan □ Low Fat □ Low Carbs
□ Paleo □ Gluten Free □ Balanced Food Groups □ Other_____

Please show usual foods and beverages:

Breakfast	Snack	Lunch	Snack	Dinner	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is Nutrition or Diet something you'd like to improve or be evaluated for? □ Yes □ No

Are you active? (check one) □ Sedentary Job w/o exercise □ Sedentary Job w/ Much Exercise
□ Sedentary Job w/ Some Exercise □ Active Job w/o Extra Exercise □ Active Job w/ Exercise
What type of exercise do you do?_____
Would you like evaluation for the best form of exercise for your body and health? □ Yes □ No

How would you characterize your life in terms of stress?: (check one)
□ High Stress □ Much Stress □ Fairly Stressed □ Mild Stress □ Periodic Stress □ Not Stressed
Would you like to be handling stress better, or reduce the effects of stress? □ Yes □ No

Do you experience any of the following moods often? (check all that apply)
□ Depression □ Anxiety □ Insecurity □ Anger □ Irritabililty □ Phobias □ Nervousness
□ Mood Swings □ Sadness □ Short Tempered □ Obsessive Thinking □ Isolated □ Hopelessness
Would you like to be evaluated for possible treatment solutions for these states? □ Yes □ No

Please check off symptoms you have had in the past 3 MONTHS.
If a *box indicates several symptoms*, please *circle the one you experience.*

Part A:

- ❑ Cough
  __ acute
  __ chronic
  __ dry
  __ phlegm, white, clear
  __ phlegm, green or yellow
  __ blood
- ❑ Sore throat
  __ itchy
  __ burning
- ❑ Hoarseness
- ❑ Frequent colds/flu's
- ❑ Swollen glands
- ❑ Painful lymph nodes
- ❑ Fever/chills
- ❑ Allergies
  __ seasonal
  __ year round
  __ pollen
  __ dust
  __ mold
  __ pets
  __ chemicals
  other _____
- ❑ Itchy eyes
- ❑ Sneezing
- ❑ Nasal discharge
  __ white, clear
  __ green, yellow
  __ odor
- ❑ Nasal congestion
- ❑ Sinus congestion
- ❑ Sinus pain
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Chest Oppression/ tightness
- ❑ Grief/ sadness
- ❑ Crave spicy foods
- ❑ Skin rashes, eczema, hives
- ❑ Spontaneous sweating

Part B:
For following symptoms indicate frequency-daily, weekly or monthly:

- ❑ Nausea _____
- ❑ Vomiting _____
- ❑ Bloating _____
- ❑ Gas _____
- ❑ Belching _____
- ❑ Acid regurgitation_____
  __ sour
  __ thin
  __ burning
- ❑ Stomach pain
- ❑ Ulcers
- ❑ Bad breath
- ❑ Gum bleeding
- ❑ Large appetite/Excessive hunger
- ❑ # of bowel movements per day ___
  __ loose
  __ hard
  __ painful
  __ blood or mucus
  __ difficult
  __ odorous
  __ burning
  __ alternating diarrhea & constipation
  __ hemorrhoids
- ❑ Fatigue or discomfort after eating
- ❑ Poor appetite
- ❑ Recent weight gain
- ❑ Recent weight loss
- ❑ Bruises easily
- ❑ Slow wound healing
- ❑ Frequently fatigued
  Time of day
  _____
- ❑ Organ prolapse
- ❑ Loss of taste
- ❑ Crave sweets
- ❑ Crave carbohydrates
- ❑ Heavy limbs
- ❑ Weak muscles
- ❑ Easily worried, over thinking
- ❑ Cloudy/ Foggy-headed
- ❑ Edema, water retention
- ❑ Varicose/spider veins

Part C:

- ❑ Irritability
- ❑ Frustration
- ❑ Easily stressed/tense
- ❑ Easily angered
  __ frequent outbursts
- ❑ Rib side pain
- ❑ Frequent sighing
- ❑ Sensation of something in throat
- ❑ Dizziness
  __ postural
  __ empty headed
  __ heavy headed
- ❑ Vertigo
- ❑ Dry hair, skin, nails
- ❑ Dry eyes, floaters, blurred vision
- ❑ Red eyes
- ❑ Eye pain/strain/sensitivity
- ❑ Neck and shoulder tension
- ❑ Tremors
- ❑ Numbness
- ❑ Hiccups
- ❑ Bitter taste in mouth
- ❑ Clearing throat often

FOR WOMEN:

First day of last period_____
# of days in menstrual cycle_____
# of days of bleeding _____
# of pads/tampons per day_____
Color of blood: __ pale__ purple __ bright red __ dark red __ brown

- ❑ Clots
  - __ red
  - __ purple
  - __ small (cottage cheese)
  - __ large
- ❑ Cramping
  - __ before
  - __ during
  - __ end
- ❑ PMS symptoms
  - __ mood changes
  - __ breast tenderness/swelling
  - __ food cravings
  - __ headaches
- ❑ Bleeding in between periods
- ❑ Fibroids
- ❑ Breast lumps/fibrocystic
- ❑ Hot flashes

# of pregnancies ____
# of live births ____

Type of birth control _____

- ❑ Pregnant
- ❑ Nursing
- ❑ Abnormal pap test
- ❑ History of vaginal warts
- ❑ Vaginal pain
  - ___with sexual intercourse
- ❑ Vaginal discharge
- ❑ Infertility
- ❑ GYN surgeries (date/type) _____ _____
- ❑ Regular breast exam

Part D (Everyone):

- ❑ Low back, knee pain
- ❑ Poor hearing/hearing aid # of years _____
- ❑ Ear ringing
- ❑ Hair loss
- ❑ Premature graying
- ❑ Cold hands & feet
- ❑ Generalized cold feeling
- ❑ Warm body temperature
- ❑ Frequent urination
- ❑ Scanty urination
- ❑ Night urination
- ❑ Urgent urination
- ❑ Profuse urination
- ❑ Color of urination
  - __ Dark __ Straw
  - __ Light/clear__ Cloudy
  - __ Bloody__ Painful
- ❑ Hesitant urination/dribbling
- ❑ Sex drive/libido __Low __High
- ❑ Puffy beneath eyes
- ❑ Dark circles under eyes
- ❑ Fear/ phobias/ inventing worst case scenarios
- ❑ Lack of will/drive/motivation
- ❑ Crave salt
- ❑ Swollen ankles
- ❑ Birth disorders/defects
- ❑ Childhood developmental problems
- ❑ Osteoporosis
- ❑ Poor teeth

FOR MEN:

Last prostate exam_____
PSA results _____

- ❑ Prostatitis/BPH
- ❑ Infertility
  - __Low sperm count
  - __Poor sperm mobility
  - __Low sperm progression
- ❑ Erectile Dysfunction (ED)
  - __ Difficulty achieving erection
  - __ Difficulty maintaining erection
  - __ Premature ejaculation

Part E (Everyone):

- ❑ Palpitations
- ❑ Difficulty falling asleep
- ❑ Wake during night
- ❑ Restless
- ❑ Night sweating
- ❑ Thirst
- ❑ Dry mouth/throat
- ❑ Mouth sores/sore tongue
- ❑ Poor memory
- ❑ Jittery, easily startled
- ❑ Anxiety
  - __ Racing thoughts
  - __ Overwhelm
- ❑ Depression

HEADACHE:

Location:
__ top
__ temples
__ forehead
__ back of head

How long? _____
Time of day: _____

Type of pain:
__ dull
__ sharp/stabbing
__ distended/throbbing
__ heavy headed
__ band like

Visual Problems:
__ see lights
__ see auras

- ❑ Dislike light
- ❑ Dislike noise
- ❑ Worse with stress
- ❑ Worse with fatigue
- ❑ Empty-headed
- ❑ Dizziness
- ❑ Nausea/Vomiting

BODY PAIN:

Date began: _____ Cause: _____

Describe location: _____

_____

Type of Pain:
__dull/achy
__sharp/stabbing
__burning
__constant
__intermittent
How often ?_____
Time of day_____
__radiating
__fixed
__moves around
__severe
__moderate
__mild discomfort

What makes it better?
__Cold
__Heat/hot shower
__Pressure/massage
__Activity/movement
__Rest

What makes it worse?
__Cold
__Cold/damp weather
__Rest
__Activity/movement
__Pressure/massage

- ❑ Numbness (no feeling)
- ❑ Pins and needles

Diagnostic Tests:
(List date/findings)
X-Ray_____
MRI_____
CAT_____
Surgeries (date/type):
_____
_____

*** MYMOP2 ***

Full name ..... Date of birth .....

Address and postcode.....

.....

Today′s date ..... Practitioner seen .....

Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines.

Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

SYMPTOM 1: 0 1 2 3 4 5 6

.....As good as it could be As bad as it could be

SYMPTOM 2: 0 1 2 3 4 5 6

.....As good as it could be As bad as it could be

Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

ACTIVITY: 0 1 2 3 4 5 6

.....As good as it could be As bad as it could be

Lastly how would you rate your general feeling of wellbeing during the last week?

0 1 2 3 4 5 6
As good as it could be As bad as it could be

How long have you had Symptom 1, either all the time or on and off? Please circle:

0 - 4 weeks 4 - 12 weeks 3 months - 1 year 1 - 5 years over 5 years

Are you taking any medication FOR THIS PROBLEM? Please circle: YES/NO
IF YES:

1. *Please write in name of medication, and how much a day/week*

.....
2. Is cutting down this medication: Please circle:

Not important a bit important very important not applicable

IF NO:
Is avoiding medication for this problem:

Not important a bit important very important not applicable

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OFFICE POLICIES

CANCELLATION POLICY

Notification of cancellation or re-scheduling must be received **By Telephone or text** during business hours on **Weekdays** (**Monday through Friday**). Acupuncture visits are generally scheduled a week or more in advance. Your appointment time is being held for you. P**lease give as much notice as is possible** when cancelling or **re-scheduling visits** so that the appointment times may be made available for scheduling other patients.

Be aware: if you do not give 2 full business day's notice of the appointment time change a $45.00 cancelation fee will be charged. (Must notify by Thursday morning for a Monday cancellation, or Friday morning for a Tuesday cancellation).

Schedule acupuncture treatments **prior to other** professional or medical **appointments**. If an earlier appointment or meeting runs late, causing you to unexpectedly miss your acupuncture visit, this will be considered a same day cancellation and the cancellation fee will be incurred. You will not be charged for true emergencies or illnesses.

I _____ have received and read the cancelation policy and understand I will be charged a $45.00 cancelation fee if I do not provide **2 full business day's** notice when canceling or rescheduling an appointment.

_____ _____

Signature Date

APPOINTMENT SCHEDULING

This office strives to run on time. Please allow one hour for acupuncture or NAET only, 1 hour 15 minutes for acupuncture with granulated herbs and one and one half hours for acupuncture and raw herbs. Please notify **upon arrival** if you have a time constraint after your treatment and must leave punctually or early.

If a new, acute condition or illness arises, please keep your scheduled acupuncture appointment. The new condition will be treated with Chinese medicine. If you have a cold or flu, please stay home to avoid exposure to others. You can have a phone consultation for herbs instead of your scheduled treatment.

SHOULD I KEEP MY APPOINTMENT IF I'M SICK?

Every so often a patient will call to cancel an acupuncture appointment because "I'm sick". This reasoning perplexes acupuncturists, because if you're sick, why not keep your appointment so that your practitioner can treat the acute illness?

Acupuncture and Chinese herbs are highly effective for treating acute conditions, such as colds, flu, stomach viruses & headaches. Patients report immediate improvement in symptoms after acupuncture treatment and herbal therapy. Happy patients frequently say, "as soon as I started taking the herbs I felt better!"

Many patients call immediately to schedule a treatment when they first notice cold or flu symptoms. These include healthcare practitioners who don't want to get their patients sick, business professionals who are too busy for a sick day or two, and patients who are chronically ill and can not afford another long recuperation period. To avoid being contagious to others, request an herbal consultation instead of an acupuncture treatment.

So if you're sick, call your acupuncturist and make an appointment for a phone consultation for Chinese herbs. If you have an appointment scheduled, a phone consultation can be done instead of the scheduled treatment.

ACUPUNCTURE TREATMENT GUIDELINES

What should I wear for acupuncture treatments?
Wear comfortable, loose fitting clothing. Most of the acupuncture points needled are on the limbs, below the elbows and knees, so be sure pants and long sleeves may be rolled up past those joints.

Other Reminders:
Remember to eat before your treatment. You should have a meal 1-3 hours prior to the treatment. If you are not able to eat a full meal, then be sure to have a lite snack (eg.hard boiled egg) ½-1hour prior to your treatment. It is best not to have sex the day of the treatment (this scatters your Qi – energy). At minimum allow a 4-5 hour interval. Work out prior to your treatment, or wait several hours before engaging in heavy exercise. It is recommended to do other therapies (chiropractor, massage, PT) prior to your treatment.

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INFORMED CONSENT FOR TRADITIONAL CHINESE MEDICAL TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of Traditional Chinese Medicine (TCM) on me (or on the patient named below, for whom I am legally responsible) by Dr. Kathleen Bartlett, DACM, MSTOM, LAc, or any other licensed acupuncturist who now or in the future may treat me while associated with or serving as back-up to Dr. Bartlett, including those working at Bartlett Acupuncture & Herbal Medicine or at any other office or clinic, whether signatories to this form or not.

I understand that methods or treatments may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na massage (similar to acupressure) Chinese herbal medicine and nutritional counseling.

Acupuncture's effects include: normalizing physiological function, decreasing pain and treating diseases and dysfunctions of the body. I have been informed that acupuncture is a safe procedure. Occasionally, bruising or tingling or numbness may occur near the needle site which can last up to a few days following acupuncture treatment. Bruising may occur after cupping procedure. On rare occasion, a patient may experience dizziness or fainting during or immediately after acupuncture treatment. Eating within two hours prior to acupuncture treatment will generally prevent occurrence of these symptoms. There have been rare reports of infections and burns (associated with cupping or moxibustion). There have been extremely rarely reported and unusual incidences of spontaneous miscarriage, nerve damage and pneumothorax. Bartlett Acupuncture and Herbal Medicine uses sterile, disposable needles and maintains a clean and safe clinic environment. Kath Bartlett, MS, LAc is a highly trained and skilled practitioner, certified in Clean Needle Technique by CCAOM. Other than occasional and minor bruising, it is highly unlikely that any of the aforementioned, negative side effects will occur.

Positive side effects to be expected from acupuncture treatment include deep relaxation and sensation of well being, increased energy, decreased feelings of stress, decreased incidences of illness, and improved physiological and mental function of the body, mind and spirit.

Chinese herbal formulas, including plant, mineral and animal sources, are considered safe in the practice of Oriental medicine. Some of the herbs are inappropriate during pregnancy and a few of the herbs are considered toxic when taken in high dosages. Dr. Bartlett is a competent and experienced herbalist, Board Certified in Chinese Herbology and Oriental Medicine by NCCAOM. She is knowledgeable in safe dosing ranges, cautions and contraindications of Chinese herbs.

I understand the herbs may need to be prepared and the teas consumed according to the written and oral instructions provided. The herbs may have an unpleasant smell or taste. Occasional side effects causes by herbs are generally limited to gastro-intestinal symptoms, such as gas, bloating, stomachache, or changes in bowels. More rarely, headache or nausea may occur. On extremely rare occasion, a patient may experience a rash or hives, vomiting, or tingling of the tongue. Any adverse symptoms caused by herbs will stop when the herbs use is discontinues. Any symptoms persisting after cessation of Chinese herbal therapy were not caused by the herbal formula. If I experience any gastro-intestinal symptoms, allergic reactions or any other unanticipated or unpleasant effects associated with the consumption of the herbs, I will immediately inform the herbalist. Generally, the herbal prescription can be modified to prevent any adverse symptoms from continuing.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I will rely on the acupuncturist to exercise professional judgment during the course of treatment, and to act in my best interest based on the available facts then known. If I become pregnant, I will notify the acupuncturist immediately.

I have read (or have had read to me) the above consent for Traditional Chinese Medical treatment, and my questions have been answered regarding its content. By signing below I agree to receive the above named procedures, and any other techniques comprising Oriental Medicine. I understand that results are not guaranteed. I intend this consent form to cover the entire course of treatment for my present condition, and any future condition for which I may seek treatment.

_____
Patient's Name

_____ _____
Patient's Signature (or representative of patient) Relationship to Patient

_____ _____
Date Office Signature (Date)

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HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996

NOTICE OF PRIVACY and SECURITY PRACTICES

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

Patient Health Care Information Use & Disclosure

Your protected health information will be used to treat you, to work with your insurance company for payment purposes, and to carry out healthcare operations. We may also use or disclose your protected health information for internal / external utilization review and/or quality assurance purposes.

We will not release your health information to other people, unless you specifically authorize us to do so, in writing.
You may revoke this authorization at any time.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

We will contact you in order to carry out efficient healthcare. We may contact you by phone, mail, email, or text to provide appointment reminders or information about treatment alternatives, or other health-related benefits or services. We may disclose your health information to local, state or federal law agencies for activities authorized by law.

Practice Duties Regarding Your Health Care Information

Bartlett Acupuncture & Herbal Medicine is required by law to maintain the privacy of protected health information. We must also provide patients with notice of its legal duties and privacy practices with respect to protected health information. Bartlett Acupuncture & Herbal Medicine is required to abide by the terms of the notice in effect. We reserve the right to change these policies and must inform you of these changes. We will inform you of these changes when you arrive at the office for your next appointment.

Patient Rights Regarding Their Health Care Information

- The patient has the right to restrict use and disclosure of protected health information.
- Bartlett Acupuncture & Herbal Medicine is not required to agree to the requested restrictions, if we believe the restrictions would affect our ability to provide care.
- The patient has the right to receive confidential communications of protected health information.
- The patient has the right to inspect and copy protected health information.
- The patient has the right to request an amendment to their protected health information in the medical record.
- The patient has the right to instruct their doctor to withhold information about treatment if the services rendered are paid for in cash.
- **Access**: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time.. If you request copies, we will charge you $1.00 for each page, $30 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summery or an explanation of your health information for a fee.

If you have questions about this notice, please contact our office.

I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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HOW TO SPEAK EFFECTIVELY WITH YOUR DOCTOR

Visiting a healthcare practitioner requires good communication skills on behalf of both patients and doctors. Patients need to be able to convey medical information in a clear and concise manner. Practitioners must be able to tell patients in plain English what is causing their symptoms and what must be done to treat the condition effectively. During the discourse, key information often does not get relayed, for a variety of reasons. What can you do to communicate more effectively with your doctor?

1) Treat your doctor visit as a business meeting. You have a short amount of professional time to relay much key information about your condition. Manage the time wisely.
2) It's your responsibility to communicate key information in an orderly fashion: such as medical background and symptomatic progression of medical events. If you have a number of health concerns to discuss, prepare in advance for the meeting. Organize your thoughts and take notes about key symptoms so that you can convey the information as clearly and succinctly. If you have a complicated medical history, prepare a written timeline of key events and interventions.
3) Keep to the symptoms: refrain from anecdotal stories. It's easy to go off on a tangent about your visit to your aunt's when you noticed the ache in your back. These stories waste precious professional time that should be spent discussing your symptoms and treating your disease. Stay focused on your history & symptoms.
4) Be able to answer detailed questions clearly. Be specific and avoid vagaries when describing your symptoms. If your doctor asks about something you haven't paid much attention to; rather than giving information that doesn't answer the question, say 'I'm not sure', or 'I don't have an answer for that'. Make a mental note to observe your body between visits so you can provide more complete information on a subsequent visit.
5) If you have a number of symptoms that you are managing, keep a log of frequency, severity, time and duration, location and any other characteristics your practitioner typically asks about. It's often difficult to recall this information when the doctor asks, so write it down in advance and give your practitioner a copy.
6) If you are on many medications, keep a log of the drugs, dosages and times taken so that you can give a copy to your doctor. Especially in the western medical community, where you see a different specialist for separate conditions, the doctors are often not aware that a patient is on many other drugs in addition to what s/he is prescribing. This leads to over prescribing and drug interactions. It is vital that all of your healthcare practitioners are aware of your drug use and history.
7) Be honest. Don't lie or withhold information. Don't exaggerate or play down symptoms. Giving inaccurate information may lead to misdiagnosis and treatment.
8) Don't be embarrassed to talk about your bodily functions. Remember, to your doctor these are routine conversations: discussing urine and bowel habits are no different than talking about an oil leak in your car.
9) Try not to interrupt your doctor's thought process during pauses or while taking notes. S/he is reviewing your case, looking for any holes in the medical history that require further illumination, and mentally arriving at diagnostic and treatment options for you. Do a self-review of your own. Have you communicated all that your doctor should know? Did you omit anything or should you convey something differently?
10) When your doctor goes over diagnostic and treatment options for you, be sure you understand what is being said. In the medical community there is a tendency to speak in jargon. Don't be intimidated by words you don't understand. Ask for an explanation of terminology. You are being given a lot of new information. Take notes during explanations and instructions that you can refer to later when memory lapses.
11) Refrain from interrupting your practitioner during explanations: often your questions will be anticipated and answered. Your doctor may forget where s/he left off and this may prevent necessary information from being provided to you.
12) It is vital that you understand your treatment and care. Know what the drugs, herbs or nutritional supplements that are being prescribed are doing. Ask for a timeline so you know what to expect and when in terms of recovery and when therapy should be discontinued.
13) Be sure your doctor has fully disclosed all possible risks and side-effects of treatment, and know what to be alerted for should treatment go array. This is especially important for drug therapy and surgeries.
14) Organize your questions before your visit. Your doctor has to work within the timeframe of the clinic schedule. Don't corner your practitioner after the visit has concluded with questions you forgot to ask during your appointment. This will delay other patients who are waiting. The time will have to be made up by shortening another patient's treatment.

YOUR DOCTOR VISIT IS A PROFESSIONAL APPOINTMENT. TREAT IT AS SUCH. ARRIVE PROMPTLY AND BE PREPARED FOR YOUR VISIT. BY FOLLOWING THESE GUIDELINES YOU WILL GET THE MOST EFFICIENT AND EFFECTIVE CARE POSSIBLE FROM YOUR HEALTHCARE PROFESSIONAL.