This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have any questions, please ask. Thank you.

Personal Information

Name_______________________________________ Date__________________________

Home Address ____

City________________________________ State_________________ Zip____________

Home Phone_________________________ Work Phone_____________________________

Cell Phone __________________________ E-mail _________________________________

Occupation_____________________ Person responsible for your account________________

Who should we thank for referring you to this office? _________________________________

Sex: Male__ Female __ Height_______ Weight_______ Birth date__________ Age____

Marital Status: Married___ Single___ Divorced___ Widowed___ Number of children____

Have you received acupuncture therapy before? Yes__ No__

When?__________________________ With whom?______________________

Please indicate any significant illness you or a blood relative (grandparent, parent or sibling) have had:

Illness	You relative	Your date	Approx.	Illness	You	Your relative	Approx. date
Cancer	____	____	________	Diabetes	____	____	______
Hepatitis	____	____	________	Heart Disease	____	____	______
High blood pressure	____	____	________	Seizures	____	____	______
Rheumatic Fever	____	____	_______	Emotional Disorders	___	____	______
Infectious Disease	____	____	________	Tuberculosis	____	____	______

Sexually Transmitted Diseases: Gonorrhea___ Syphilis___ AIDS___ HPV___ Chlamydia___ Herpes___ Date_________

List any medications and supplements you are currently taking(continued on back if necessary)

Medicine and Dosage	Reason	How long?	Prescribed by	Date of last check up

Please indicate the use and frequency of the following:

	Yes	No	How much?
Coffee/black tea	____	____	_________
Non-medical drugs	____	____	_________
Tobacco	____	____	_________
Alcohol	____	____	_________
Water intake	____	____	_________
Soda drinks	____	____	_________

What are the main health problems for which you are seeking treatment?

____

____

What other forms of treatment have you sought?

____

____

List any other health problems you now have.

____

____

List any allergies, food sensitivities or food cravings that you have.

____

____

List any accidents, surgeries, or hospitalizations (include date).

____

____

Lab Results (please include copies)

____

How do you feel about the following areas of your life? (please check the appropriate spaces and indicate any problems you may be experiencing)

	Great	Good	Fair	Poor	Bad
Significant other	_____	_____	_____	_____	_____
Family	_____	_____	_____	_____	_____
Diet	_____	_____	_____	_____	_____
Sex	_____	_____	_____	_____	_____
Self	_____	_____	_____	_____	_____
Work	_____	_____	_____	_____	_____
Exercise	_____	_____	_____	_____	_____
Spirituality	_____	_____	_____	_____	_____

Your Comments:

____

____

Women

Age of first period (menarche)_______ Age of last period (menopause)______

Number of days between periods______ Number of days of flow______

Color of flow_____ Clots? Yes___ No___ Color_______

Average number of pads you use per day:

1st day_____ 2nd day_____ 3rd day_____ 4th day_____ + days_____

Have you been diagnosed with: Fibroids____ Fibrocystic Breasts____

Endometriosis____ Ovarian cysts____ PID____ Other____

Location of pain: Lower abdomen___ Lower back___ Thighs___ Other__________

Nature of pain (please indicate before, during or after menses):

Cramping__________ Stabbing__________ Burning ___________

Aching ___________ Dull _____________ Bloating__________

Constant__________ Intermittent________

Bearing down sensation______________________

Other symptoms related to menses:

Discharge___ Vaginal Dryness___ Headache___

Nausea ___ Constipation ___ Diarrhea ___

Swollen Breasts ___ Mood swings ___ Ravenous appetite ___

Poor appetite ___ Hot flashes ___ Night sweats ___

Increased libido ___ Decreased libido ___ Insomnia ___

Are you pregnant? Yes___ No___ # of pregnancies _____ # of live births____

# of abortions ____ # of miscarriages ____

Date of last: Gynecologic exam ________ Pap smear_______ Mammogram_____

Bone Density scan________ Results ________________________

For Men

Date of last prostate check up __________ PSA results_________________

Manual prostate exam results____

Lab Results:

Frequency of Urination: daytime _________ Nighttime________

Color of urine: clear ____ murky_____ Odor:_________________________

Symptoms related to prostate:

Prostate problems __ Delayed stream __ Dribbling __

Rectal Dysfunction __ Incontinence __ Retention of Urine __

Back pain __ Increased Libido __ Decreased Libido __

Premature Ejaculation__ Impotence __ Groin pain __

Testicular pain __ Other:

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
NO MARK ( ) = NEVER EXPERIENCE CHECK MARK (√) = SOMETIMES EXPERIENCE
PLUS SIGN (+) = FREQUENTLY EXPERIENCE

___ lack of appetite ___excessive appetite ___loose stool or diarrhea
___digestive problems, indigestion ___vomiting ___belching, burping
___heartburn/ reflux ___feeling the retention of ___tendency to become obsessive
food in stomach in work, relationships …

___insomnia, difficulty sleeping ___heart palpitations ___cold hands and feet
___nightmares ___mentally restless ___laughing for no apparent
reason
___angina pains ___abdominal pains ___chest pain
___sciatic pain ___headaches ___pain or coldness in the genital
area

___cough ___shortness of breath ___decreased sense of smell
___nasal problems ___skin problems ___feeling of claustrophobia
___bronchitis ___colitis or diverticulitis ___constipation
___hemorrhoids ___recent use of antibiotics ___eye problems
___jaundice (yellowish eyes or skin)___difficulty digesting oily foods ___gall stones
___light colored stool ___soft or brittle nails ___easily angered or agitated
___difficulty in making plans/decisions ___spasms or twitching of muscles
___low back pain ___knee problems ___hearing impairment
___ear ringing ___kidney stones ___decreased sex drive
___hair loss ___urinary problems ___fatigue
___edema ___blood in stool ___black tarry stool
___easily bruised ___difficult to stop bleeding ___asthma
___tendency to catch colds easily ___intolerance to weather changes ___allergies
___hay fever ___dizziness ___tendency to faint easily
___high cholesterol levels ___sudden weight loss

CHIROPRACTIC AND ACUPUNCTURE INFORMED TO CONSENT TO TREAT

INFORMED CONSENT:

I hereby request and consent to the performance of acupuncture and chiropractic treatments and other procedures within the scope of the practice of acupuncture and chiropractic on me (or on the patient named below, for whom I am legally responsible) by the practitioner named below and/or other licensed practitioner who now or in the future treats me while employed by, working or associated with or serving as back-up for the doctor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese message), Chinese herbal medicine, and nutritional counseling. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risk may occur. The herbs and nutritional supplements (which are from plants, animal and mineral sources) that have been recommended are traditionally considered safe in a practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based upon the facts then known, is in my best interests.

I have had an opportunity to discuss with the doctor of chiropractic and acupuncture named below and/or with other office of clinic personnel the nature and purpose of a chiropractic adjustments, procedures, and acupuncture adjustments. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask question about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_________________________ ______________

Patient Signature Date

_________________________ _____________

Provider Signature Date

Notice of Privacy Practices for HIPAA Regulations

This note describes general office practices regarding confidentiality of your medical information.

Office Practices:

- All information regarding patients, their treatments, diagnosis and appointments iskept strictly confidential within the confines of the practitioner and office assistant. Patient chart and financial data will be seen only by practitioner and office assistant.
- Electronic data transfer from this office is limited strictly to electronic claims filing for insurance reimbursement.
- For treatment purposes, information will be provided to another practitioner only after your written consent is given.
- Discussion of treatment is confined to the consultation room or the treatment room, and will never be held in the presence of other individuals.

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how medical information may be used and disclosed in this office and have been informed on how I may gain access to and control this medical information.

____

Signature of Patient or Patient Representative

____

Print Name of Patient or Patient Representative

____

Description of Personal Representative

____

Date

FINANCIAL AGREEMENT

Assignment of Benefits for Insurance

I authorize payment of benefits be made directly to the above-named healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process claims in conjunction with my treatment(s) by this provider.

Cancellation Policy

Please be respectful of the time set aside for your treatment. If you need to change or cancel an appointment, be sure to make up the missed appointment within a week so that the effects from the treatments are not interrupted.

All scheduled appointments require a 24 hour cancellation notice, otherwise the patient will be charged a $ 65.00 missed appointment fee.

Returned Check Policy

All returned checks will be subject to an additional charge of $ 25.00.

If chiropractic and acupuncture are performed on the same day patient is responsible for both copayments

By signing this agreement, I am acknowledging that I have read the above financial policies and will be responsible for ALL charges stated above.

Patient Signature Date