

# WELLSPRING OF LIFE ACUPUNCTURE

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Name:		Date of Birth:	
Address:		City:	Zip code:
Phone:		Email:	
Emergency Contact:		Phone:	
Age:	Height:	Weight:	Occupation:
Have you ever received acupuncture before:		If so, when?:	
How did you hear about us?:			
Do you have health insurance?			

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

<u>Illness</u>	<u>You</u>	<u>Relative</u>	<u>Approx. Date</u>	<u>Explain</u>
Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Current Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**List any medication & supplements you are currently taking:**

Medication:	Dosage:	For how long:	Prescribed by:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Check the box if any of the following are true:**

- I have known allergies       I am taking Coumadin/Warfarin or similar medication   
I have a pacemaker       I am taking Lithium (Eskalith, Lithobid, Lithonate)

**The following is a list of symptoms that you may or may not experience:**

Leave blank=never; Check mark (✓) if sometimes; Plus sign (+) if frequent

- |                            |                           |                           |
|----------------------------|---------------------------|---------------------------|
| ___ fatigue                | ___ nightmares            | ___ soft or brittle nails |
| ___ lack of appetite       | ___ mental restlessness   | ___ ear ringing           |
| ___ excessive appetite     | ___ chest pain            | ___ dizziness             |
| ___ sudden weight loss     | ___ abdominal pain        | ___ jaundice              |
| ___ loose stools/diarrhea  | ___ sciatic pain          | ___ gallstones            |
| ___ constipation           | ___ headaches             | ___ kidney stones         |
| ___ hemorrhoids            | ___ low back pain         | ___ urinary problems      |
| ___ colitis/diverticulitis | ___ knee problems         | ___ edema/swelling        |
| ___ digestive problems     | ___ pain/cold in genitals | ___ decreased sex drive   |
| ___ blood in stool         | ___ muscle twitches       | ___ catch colds easily    |
| ___ black tarry stool      | ___ cough                 | ___ allergies/hay fever   |
| ___ heartburn/reflux       | ___ shortness of breath   | ___ high cholesterol      |
| ___ nausea/vomiting        | ___ bronchitis            | ___ tendency to faint     |
| ___ belching/burping       | ___ asthma                | ___ easily fearful        |
| ___ easily bruised         | ___ recent antibiotic use | ___ easily angered        |

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

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**What other treatments have you tried?**

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**List any accidents, surgeries, or hospitalizations:  
(include event & date)**

<hr/>	<hr/>
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<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

**Explain anything else that you feel is pertinent to your condition that wasn't asked:**

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**How do you feel about the following areas of your life? Check appropriate box**

	<b>Great</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>	<b>Bad</b>
Significant other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## HIPPA Notice of Privacy Practices

This form describes how medical information about you may be used and disclosed and how you can get access to this information.

This notice of privacy practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for purposes that are permitted or required by law.

Your protected health information may be used and disclosed by your physician, staff, or others outside of the office that are involved in your care and treatment.

We will use and disclose your PHI to provide, coordinate, or manage your health care.

Your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information.

Your PHI will be used, as needed to obtain payment for you health care services.

We may use or disclose your PHI as necessary to contact you reminding you of an appointment or to wish you a "Happy Birthday".

At times, we may use or disclose of your PHI without your authorization. These situation would include: as required by law, public health issues required by law, communicable diseases, health oversight, criminal activity, military activity, and national security.

Other permitted and required uses will be made only with your consent, authorization, or opportunity to object unless required by law.

You do have the right to inspect and copy your PHI under federal law. You also have the right to request a restriction of your PHI.

Your physician is not required to the restriction you request. You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.

We reserve the right to change the terms of this notice and will inform you by mail of any changes.

Print Name: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_

## Informed Consent to Acupuncture

I consent to acupuncture treatments and other procedures associated with the practice of Traditional Chinese Medicine. I have discussed the nature and purpose of my treatments with a member of the staff or acupuncturist.

I understand that methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, and massage.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the needling sites that may last a few days, as well as 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 this office uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and heat lamps. I understand that while this document describes the major risks of treatment, other side effects may occur.

The herbs and nutritional supplements(which are from plant, animal, and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. I understand that herbs may need to be prepared and the tea consumed according to the instructions provided orally and in writing. I will notify a member of the staff if I become pregnant.

I do not expect the staff to be able to anticipate and explain all possible risks and complications of treatment and wish to rely on the staff to exercise judgment during the course of treatment.

Print name: \_\_\_\_\_ Sign name: \_\_\_\_\_ Date: \_\_\_\_\_

## For Women

Age of 1st period (menarche)\_\_\_\_\_ Are you pregnant\_\_\_\_\_

Age of last period (menopause)\_\_\_\_\_ # Live births\_\_\_\_\_#Abortions\_\_\_\_\_

#Miscarriages\_\_\_\_\_ Are you currently trying to get pregnant\_\_\_\_\_

Form of birth control(if applicable)\_\_\_\_\_ For how long\_\_\_\_\_

Date of last Gyn exam\_\_\_\_\_Pap smear\_\_\_\_\_Mammogram\_\_\_\_\_

Any abnormal findings\_\_\_\_\_

Menses: # days between periods\_\_\_\_\_# days of flow\_\_\_\_\_Color\_\_\_\_\_

Any Clotting?\_\_\_\_\_Average # pads/tampons you use per day\_\_\_\_\_

If menstrual pain, locations of pain:  lower abdomen lower back legs other

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

Cramping\_\_\_\_\_Stabbing\_\_\_\_\_Burning\_\_\_\_\_Aching\_\_\_\_\_

Dull\_\_\_\_\_Bloating\_\_\_\_\_Consistent\_\_\_\_\_Intermittent\_\_\_\_\_

### **Other symptoms related to menses: (check if applicable)**

- |  |                                       |   |  |   |
|--|---------------------------------------|---|--|---|
| <input type="checkbox"/> Discharge       | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Night sweats       | <input type="checkbox"/> Swollen breasts | <input type="checkbox"/> Mood swings      |
| <input type="checkbox"/> Insomnia        | <input type="checkbox"/> Hot flashes  | <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Headache        | <input type="checkbox"/> Increased libido |
| <input type="checkbox"/> Poor libido     | <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Nausea          | <input type="checkbox"/> Constipation     |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Breast lumps |   |  |   |

### **Have you been diagnosed with:**

- |                                   |                                      |  |  |
|-----------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> PID         | <input type="checkbox"/> Fibrocystic breasts | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> PCOS     | <input type="checkbox"/> Infertility | <input type="checkbox"/> Endometriosis       | <input type="checkbox"/> Other         |

## **Wellspring of Life Acupuncture**

### **RESCHEDULING & CANCELLATION POLICY**

**AS OF JANUARY 1, 2016**

In order to provide timely and quality service to our patients, we ask that you please be on time to your appointment. If you are running more than 15 minutes late, we reserve the right to reschedule you at a later time/date. Please call the office if you are aware that you will be running late to an appointment.

Please call at least 24 hours in advance if you need to cancel or reschedule. Failure to do so will result in being charged for your appointment. We ask that you please be mindful of others that could have had your appointment time, if not cancelled at last minute. We will do our best to get you into the times and dates that you request.

I read the statements above and understand that these are the policies of Wellspring of Life Acupuncture.

Please sign \_\_\_\_\_

Date \_\_\_\_\_