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:

Illness	You	Relative	Approx. Date	Explain
Emotional Disorders	☐	☐	____________	________________
Hepatitis	☐	☐	____________	________________
Hypertension	☐	☐	____________	________________
Heart Disease	☐	☐	____________	________________
HIV	☐	☐	____________	________________
Seizures	☐	☐	____________	________________
Cancer	☐	☐	____________	________________

Current Physician:___________________________ Phone:_____________________________________

List any medication & supplements you are currently taking:

Medication: Dosage: For how long: Prescribed by:

____

____

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____

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?

What other treatments have you tried?

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

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

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

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

HIPAA 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)

☐Discharge ☐Diarrhea ☐Night sweats ☐Swollen breasts ☐Mood swings

☐Insomnia ☐Hot flashes ☐Increased appetite ☐Headache ☐Increased libido

☐Poor libido ☐Insomnia ☐Decreased appetite ☐Nausea ☐Constipation

☐Vaginal dryness ☐Breast lumps

Have you been diagnosed with:

☐Fibroids ☐PID ☐Fibrocystic breasts ☐Ovarian cysts

☐PCOS ☐Infertility ☐Endometriosis ☐Other

Wellspring of Life Acupuncture

RESCHEDULING & CANCELLATION POLICY
AS OF OCTOBER 1, 2017

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 a cancellation fee of $ 45.00. I authorize Wellspring of Life Acupuncture to charge my credit card on file in the amount of $45.00. We ask that you please be mindful of others that could have had your appointment time, had you cancelled in a timely manner. 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_________________