The Center of Wellness

Today's date: _____

Name:		Age:	M / F
Address:	Zip Code:	Date of Birth:	
Phone (call): H C W	Phone (text): H C W		
Email:	Preferred Method of Contact: Phone Email Text		
Occupation:	Employer:	Marital Status: M S D W O	
Emergency Contact Name:	Phone:	Relation to Patient:	
Main reason for visit:			
Date of onset of primary complaint:	How did you hear about us?:		
Do you have health insurance? Yes No If Yes, who is your provider?	Do you wish to use your health insurance? Y N	If Y, please bring your insurance card to the front desk.	
If your complaints have been given a diagnosis, please describe:			
Please list any medications, herbs, supplements, etc. that you are currently taking:			
If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to:			

Consent for Treatment:

By signing below, I do hereby voluntarily consent to be treated by The Center of Wellness. Although holistic healthcare is extremely effective, I accept that no guarantee is made concerning the results of my treatment, and I have been informed that I may stop treatment at any time.

I understand that methods or treatments suggested throughout the course of my care may include but are not limited to massage therapy, chiropractic care, psychotherapy/life coaching, music therapy, neurofeedback, acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, organic facials, and/or food therapy.

I wish to rely on my practitioner to exercise judgment during the course of the treatment, which the practitioner feels at the time, is in my best interests. I have been informed that acupuncture is a sage method of treatment, but occasionally there may be some bruising or swelling near the needling sites that last a few days. There may be some bruising after cupping or massage. The herbs and nutritional supplements which may be recommended are traditionally considered safe in the practice of Chinese Medicine but if I experience any adverse effects which I associate with these substances, I will discontinue use and contact The Center immediately.

By signing below, I agree to the above named procedures with the understanding that I may refuse treatment at any time. I intend this consent to cover the entire course of treatment for my present condition(s).

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

_____

Parent/Guardian Name

_____ _____

Parent/Guardian Signature (required if patient is under 18 years of age) Date

The Center of Wellness

NOTICE OF PRIVACY POLICIES
The Health Insurance Portability & Accountability Act (HIPAA)

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the purpose of treatment, payment, and healthcare operations. You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, email communications, newsletters and appointment reminders by calls, post cards or letters.

Disclosure

This office may use or disclose your Protected Health Information as required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

Questions or Concerns

If you have questions, concerns, or would like more information, please contact The Center of Wellness at info@MyCenterOfWellness.com.

Additional concerns may be directed to the US Department of Health and Human Services: DHHS (Office of Civil Rights)

200 Independence Avenue S.W., Room 509, F HHH Building Washington, DC 20201

Initial Here: _____

The Center of Wellness

Acupuncture Intake and Medical History

Please note the following for your exam:

1. You should eat food within 6 hours of receiving your treatment. If you have not, a light snack is recommended. It is important that you do not eat a heavy meal or drink alcohol right before your treatment.
2. Depending on the nature of the complaint, needles may be retained for various lengths of time, and additional modalities may need to be used, thus resulting in varying treatment times.
3. It is not always necessary to disrobe. Depending on where the needles are placed, specific articles of clothing may need to be removed. It is advisable to wear undergarments since it is not always possible to cover the body completely.
4. For accurate diagnosis, it is important to examine your tongue. If possible, do not brush your tongue the day of your exam and treatment. Additionally, try to avoid coffee, tea, or hard candies within 2 hours of treatment as these will falsely discolor the tongue.
5. Only pre-sterilized, disposable acupuncture needles are used. Needles are not reused.

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.

GENERAL PATIENT INFORMATION

Height: ____ ' ____ " Weight: _____ lbs SSN (optional): _____

How did you hear about us?

_____

_____

MAJOR COMPLAINTS, IN ORDER OF IMPORTANCE

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Any serious injuries? Y N

If yes, list your injuries:

_____

_____

_____

How do these complaints/conditions impair your daily activities?

_____

_____

_____

INFORMATION FOR YOUR ACUPUNCTURIST

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.

Patient medical history

How was your childhood health? _____

How many times have you stayed in the hospital? _____
For what reason(s)?

_____

_____

Check any that you have had in the past:

❑ Diabetes	❑ Allergies	❑ Glaucoma	❑ Rheumatic Fever
❑ Heart Disease	❑ CVA (stroke)	❑ Vein Condition	❑ Thyroid Disorder
❑ Asthma	❑ Pneumonia	❑ Tuberculosis	❑ Emphysema
❑ Jaundice	❑ Gonorrhea	❑ Mumps	❑ Bleeding Tendency
❑ Syphilis	❑ Measles	❑ Chicken Pox	❑ Nervous Disorder
❑ Meningitis	❑ HIV	❑ Polio	❑ Mononucleosis
❑ Epilepsy	❑ High Fever	❑ Hepatitis	❑ Multiple Sclerosis
❑ Paralysis	❑ Cancer	❑ Migraines	❑ High Blood Pressure
❑ Other Lung Illness	❑ Other Liver Illness	❑ Other Heart Illness	❑ Other Kidney Illness

❑ Other _____

Immunizations: _____ Any Adverse Effects? _____

Surgeries:

_____

_____

Is there anything else your practitioner should know?

_____

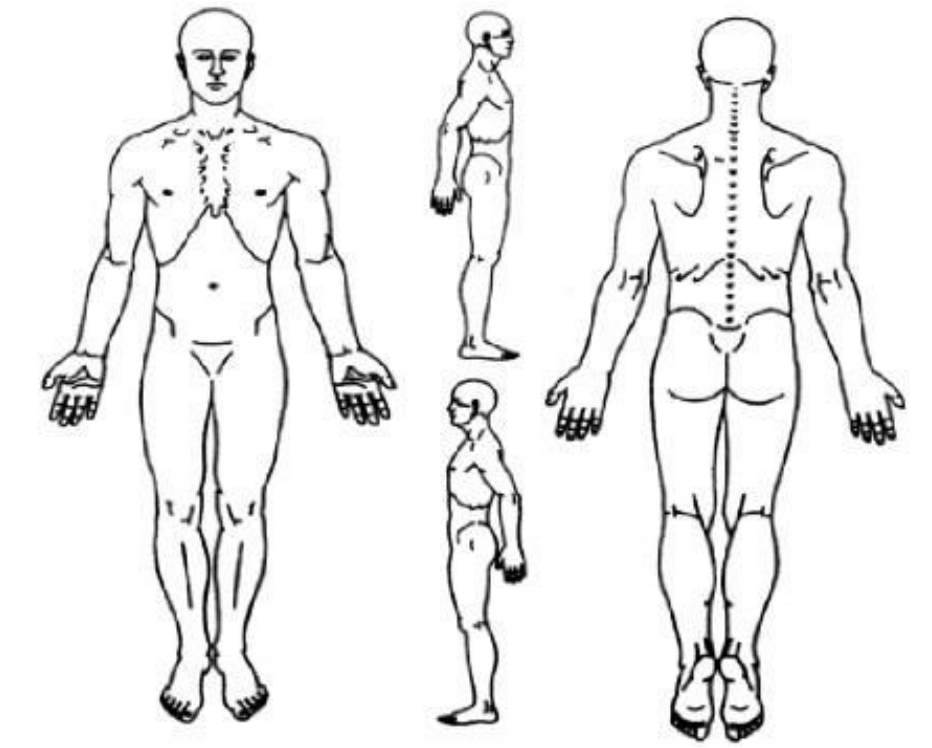
_____

_____

Pain Indication

Please circle on the image the area of your pain, if present. Indicate with a letter below the nature of pain:

A: ache **B**: burning **C**: cramping **D**: dull **SH**: sharp **N**: numb **T**: tingling **S**: stiff **W**: weak



Rate any pain you are having from 0 to 10.

Area_____: 0 1 2 3 4 5 6 7 8 9 10

Area_____: 0 1 2 3 4 5 6 7 8 9 10

Area_____: 0 1 2 3 4 5 6 7 8 9 10

Area_____: 0 1 2 3 4 5 6 7 8 9 10

What worsens your pain? _____

What relieves your pain? _____

The following checkboxes will help our acupuncturists determine which of your organs or body parts need the most care. It will also help them determine which acupuncture points to use when needling. Please check any of the following that currently pertain to you:

Overall Temperature (Kidney Function)

❑ Sweaty feet ❑ Night sweats ❑ Perspire easily

❑ Hot body temperature (sensation) ❑ Heat in the hands, feet, and chest ❑ Lack of perspiration

❑ Cold body temperature (sensation) ❑ Hot flashes any time of the day ❑ Take water to bed

❑ Afternoon flushes ❑ Thirsty

Overall Energy (Lung, Kidney function)

❑ Shortness of breath ❑ Difficulty keeping eyes open in the daytime ❑ Feel worse after exercise ❑ General weakness

❑ Low energy ❑ Easily catch colds

Overall Blood (Liver, Spleen, Heart function)

❑ Dizziness ❑ See floating black spots

Heart function

❑ Palpitations

❑ Sores on the tip of the tongue ❑ Mental confusion ❑ Wake unrefreshed

❑ Anxiety ❑ Restlessness ❑ Frequent dreams

❑ Chest pain traveling to shoulder

❑ Drink coffee (# of cups per week:_____)

Lung function

❑ Nasal Discharge (Color: _____) ❑ Coughs ❑ Dry throat ❑ Sneezing

❑ Allergies (To what?_____) ❑ Nose Bleeds ❑ Dry nose ❑ Achy feeling

❑ Headache (Location: _____) ❑ Sinus Congestion ❑ Dry skin ❑ Stiff neck

❑ Smoke cigarettes (# of cigarettes a day: ___) ❑ Dry Mouth ❑ Sore throat ❑ Stiff shoulders

❑ Alternating fever and chills ❑ Sadness ❑ Difficulty breathing ❑ Melancholy

Spleen Function

❑ Low appetite
❑ Abdominal gas
❑ Easily bruised
❑ Worry
❑ Abrupt weight gain
❑ Gurgling noise in the stomach
❑ Hemorrhoids
❑ Over-thinking
❑ Abrupt weight loss
❑ Fatigue after eating
❑ Pensive
❑ Abdominal bloating
❑ Prolapsed organs (previously diagnosed; which organ? _____)

Spleen, stomach, large intestine, small intestine function

❑ Loose bowels
❑ Incomplete
❑ Blood in stools
❑Undigested food in stools
❑ Constipated
❑ Diarrhea
❑ Mucous in stools

Dampness trapped in the body

❑ Mental heaviness
❑ Swollen hands
❑ Chest congestion
❑ Mental sluggishness
❑ Swollen feet
❑ Nausea
❑ Mental fogginess
❑ Swollen joints
❑ Snoring
❑ General sensation of heaviness in the body

Stomach function

❑ Large appetite
❑ Heartburn
❑ Belching
❑ Bad breath
❑ Acid regurgitation
❑ Hiccups
❑ Mouth (canker) sores
❑ Ulcer (diagnosed)
❑ Stomach pain
❑ Burning sensation after eating
❑ Bleeding, swollen or painful gums
❑ Vomiting

Liver, gall bladder function

❑ Alternating diarrhea and constipation
❑ Frustration
❑ Tingling sensation
❑ Convulsions
❑ Headache at the top of the head
❑ Depression
❑ Numbness
❑ Lump in the throat
❑ Tight sensation in the chest
❑ Irritability
❑ Muscle spasms
❑ Neck tension
❑ Bitter taste in the mouth
❑ Skin rashes
❑ Muscle twitching
❑ Drink alcohol
❑ High-pitched ringing in the ears
❑ Chest pain
❑ Muscle cramping
❑ Shoulder tension
❑ Gall stones (history or current)
❑ Anger easily
❑ Seizures
❑ Limited Range-of-Motion, neck
❑ Limited Range-of-Motion, shoulder
❑ Sexually transmitted disease (Which? _____)
❑ Recreational drugs (Which? _____ , How much per week? _____)
❑ Frequently unable to adapt to stress (What causes the stress? _____)

Eyes (Liver function)

❑ Itchy
❑ Dry
❑ Blurry vision
❑ Far-sighted
❑ Bloodshot
❑ Watery
❑ Decreased night vision
❑ Hot
❑ Gritty
❑ Near-sighted

Kidney, urinary bladder functio

❑ Frequent cavities
❑ Easily broken bones
❑ Sore knees
❑ Weak knees
❑ Cold sensation in the knees
❑Low back pain
❑Memory problems
❑Excessive hair loss
❑Low-pitched ringing the ears
❑Kidney stones
❑Bladder infections
❑Wake during the night twice to urinate
❑Lack of bladder control
❑Fear
❑Easily startled

Urination

❑ Normal color ❑ Reddish ❑ Profuse ❑ Painful ❑ Urgent

❑ Dark yellow ❑ Cloudy ❑ Strong color ❑ Discharge ❑ Frequent

❑ Clear ❑ Scanty ❑ Burning ❑ Difficult

Libido (Sex Drive)

❑ Normal ❑ High ❑ Low

Medications, Vitamins, and Supplements log

Medical/Allergy alerts: _____

Date Started	Medication/Vitamin/Supplement	Reason for taking	Dosage	Quantity	Frequency

WOMEN -

Regular menstrual cycle? Y ❑ N ❑ Number of children: _____

Age of first menstruation: _____ Average number of days of flow: _____

Vaginal discharge? Y ❑ N ❑ Pregnant? Y ❑ N ❑

Number of pregnancies: _____ Age of menopause (if applicable): _____

Average number of days of entire cycle: _____ Bleeding between periods? Y ❑ N ❑

Do you experience any of the following pre-menstrual symptoms?

❑ Nausea ❑ Vomiting ❑ Other: _____

❑ Food cravings ❑ Headaches _____

❑ Depression ❑ Irritability _____

Please fill out the following menstrual chart:

Day:	1	2	3	4	5	6	7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow: normal, heavy, light (N,H,L)							
Pain/cramps: dull, sharp, other (D,S,O)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other: _____							

❑ Water retention ❑ Breast swelling

❑ Migraines ❑ Breast tenderness

❑ Anxiety ❑ Other emotions: _____

❑ Sharp pain: Where? _____ ❑ Dull pain: Where? _____

Thank you! Please make sure all information provided is complete and accurate.

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