Welcome to HW Acupuncture & Wellness

Contact Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone- Preferred: _____ (circle: Home or Cell)

Other: _____ (circle: Home or Cell)

Work: _____ Date of Birth: _____

Do we have your permission to send appointment reminders, health newsletters, and occasional promotions to your email address? YES _____ NO _____

We will not sell or give your email to any other agency.

Email address: _____

Emergency Contact:

Name: _____ Telephone: _____

Relationship: _____

If you have health insurance, we will be happy to verify your benefits. If you have a discount plan through your insurance, please tell the front desk.

How did you learn about us? (Please circle)

 Sign Holder Walk-in Facebook Our Website Internet search _____ Other: _____

 Friend or Family (name)_____ Physician (name) _____ Insurance Company _____

MISSION STATEMENT

HW Acupuncture & Wellness provides information, education, and access to complementary health services for people seeking wellness. HW Acupuncture & Wellness connects practitioners and neighbors to achieve optimum health. Healthy people are the basis of a healthy and happy community.

DISCLAIMER

Merely an office location, through which independent practitioners conduct their business, HW Acupuncture & Wellness does not render any services or provide any care or treatment. The individual practitioner that performs the services is independent from HW Acupuncture & Wellness are licensed health care practitioners; some services available at HW Acupuncture & Wellness are complimentary to and not a substitution for treatment by a licensed health care practitioners. As such, by signing below, you indicate that you understand this disclaimer and agree to hold HW Acupuncture & Wellness harmless from any and all claims related to services obtained at HW Acupuncture & Wellness.

Signature: _____ Date: _____

Acupuncture Patient Information

Please complete this form as thoroughly as possible. All information is confidential.

First Name: _____ Last Name: _____ Date: _____
Gender (please circle): M F Date of Birth: _____ Age: _____
Marital Status (please circle): Single Married Partnered Separated Divorced
Place of Employment: _____ Occupation: _____

Major complaints, in order of importance to you:
Complaint #1 _____
Describe your symptoms: _____
When/how did this condition occur? _____
How does this condition impair your daily activities? _____
Treatments have you received for this condition?
_____
Get temporary relief? _____ Fixes Problem? _____Causes side Effects? _____
Complaint #2 _____
Describe your symptoms: _____
When/how did this condition occur? _____
How does this condition impair your daily activities? _____
Treatments have you received for this condition?
_____

Complaint #3 _____
Describe your symptoms: _____
When/how did this condition occur? _____
How does this condition impair your daily activities? _____
Treatments have you received for this condition?
_____

What are your goals for your acupuncture visits? _____
Have you had acupuncture treatments before? _____
Do you have any concerns about having acupuncture? _____

Please rate your commitment to feeling better: 1 2 3 4 5 6 7 8 9 10

Other Complaints/Comments: _____

Acupuncture Medical Conditions

Symptoms – Note: For each symptom you currently have, rate it severity from 1-5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE

Liver/ Gallbladder
___ Irritability/ Anger
___ Depression/ Stress
___ Headaches/ Migraines
___ Visual Problems
___ Red/ Dry/ Itchy Eyes
___ Gall Stones
___ Dizziness
___ Blurred Vision
___ Feeling of Lump in Throat
___ Clenching Teeth at Night
___ Muscle Cramping/ Twitch
___ Tension
___ Joints/ Neck/ Shoulder
___ Pain/ Tight
___ Poor Circulation
___ Soft/ Brittle Nails
___ Emotional Eater

Kidney/ urinary Bladder
___ Urinary Problems
___ Bladder Infections
___ Lack of Bladder Control
___ Weakness/ Pain in Low Back
___ Decreased Bone Density
___ Feel Cold Easily
___ Low Sex Drive
___ Excess Sexual Desire
___ Poor Memory
___ Loss of Hair
___ Hearing Problems
___ Cavities
___ Craving/ Avoiding Salty Foods
___ Fear
___ Hot Flash/ Night Sweats

Heart/ Small Intestines
___ Heart Palpitations
___ Chest Pain
___ Insomnia/ Sleep Problems
___ Easily Startled
___ Restlessness/ Agitation
___ Vivid Dreams
___ Lack of Joy in Life

Lung/ Large Intestine
___ Dry cough
___ Cough with Sputum
___ Nasal Discharge
___ Post- Nasal Drip
___ Sinus Infection/ Congestion
___ Itchy, Red, or Painful Throat
___ Dry Mouth/ Throat/ Nose
___ Skin Rashes/ Hives
___ Snoring
___ Grief/ Sadness
___ Shortness of Breath
___ Allergies/ Asthma
___ Low Tolerance to Colds/ Flu
___ Sneezing
___ Mild Fever Comes & Goes
___ Smoke Cigarettes

Energy Level –*Please Circle*
1 2 3 4 5 6 7 8 9 10

Spleen/ Stomach
___ Heaviness in Body
___ Fatigue/ Worse After Eating
___ Hard to get up in the A.M.
___ Edema (Swelling)
___ Muscles Feel Tired Often
___ Easily Bruising & Bleeding
___ Bad Breath
___ Decreased/ Increased Appetite
___Crave Sweets
___ Hypoglycemia
___ Difficulty Digesting Oily Foods
___ Nausea/ Vomiting
___ Gas/ Belching
___ Insulin Sensitivity
___ Hemorrhoids
___ Constipation
___ Diarrhea
___ Abdominal Pain
___ Indigestion/ Heartburn
___ Over- Thinking
___ Tendency to Gain Weight
___ Brain Foggy

Body Temperature
___ Cold Entire Body
___ Cold Extremities
___ Hot All Day
___ Hot Only in Afternoon
___ Hot Only at Night
___ Normal

Medical Conditions Please list conditions and surgeries you have had and year diagnosed. **Year:** **Condition:**		**Allergies** Medications, Seasonal, Environmental, Food

Medications – Please list all medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, and nose sprays.

Prescription name:	**Purpose:**	**How Often:**	**Dose:**	**Last dose:**

Women Only

Hysterectomy – Ovaries removed? ☐ Yes ☐ No

Could You be Pregnant Now? ☐ Yes ☐ No

Number of: ___ Pregnancies___ Miscarriages

___Births ___ Abortions

Post-menopausal Bleeding? ☐ Yes ☐ No

When did you last period end? _____

Number of days for monthly cycle? _____

Number of days bleeding lasts? _____

Describe Menstrual Flow:

☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of Menstrual Flow:

☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:

☐ None ☐ IUD ☐ Birth Control Pills

☐ Spermicides ☐ Barriers

Do you suffer from:

☐ Cramping (*Mark as appropriate)*

☐ Severe ☐ Moderate

☐ Mild ☐ Before Period

☐ During Period ☐ After Period

☐ Clotting (*Mark as appropriate*)

☐ Bright in color ☐ Dark in color

☐ Bleeding Between periods ☐ Infertility

☐ Pelvic Inflammation ☐ Ovarian Cysts

☐ Endometriosis ☐ Hot Flashes

☐ M stitis ☐ Breast Cysts

☐ Yeast Infection /Vaginitis /other discharge

☐ Premenstrual Syndrome (*Mark as appropriate*)

☐ Fluid Retention ☐ Cravings

☐ Fluctuating Emotions ☐ Irritability

☐ Tenderness of Breast ☐ Depression

☐ Fatigue

Men Only

☐ Impotence ☐ Weak Erection

☐ Discharge from Penis ☐ Prostate Problems

☐ Testicular Pain or Lump ☐ Infertility

☐ Premature Ejaculation ☐ Low Sex Drive

Men and Women

Supplements

Name	Purpose	How Long

Diet & Lifestyle

What kinds (circle)	How much per day/week
Sugar: Candy	
Cookies/ Baked goods	
Regular Soda /Diet soda	
Chocolate	
Dairy: Milk	
Cheese	
Yogurt	
Ice-Cream	
White Flour: Bread	
Pasta	
Coffee	
Alcohol	
Protein 50g per day?	
Eggs	
Dark green /vegetables	
Fruits	
Eat Breakfast?	
Eat fast food /on the run?	

Additional Notes

Please tell us about your exercise (regular, minimal, etc.)

_____

Please list what you ate yesterday:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Personal Medical & Family Health History

Please indicate those that are current health problems for yourself and your family members with a "**C**" under the appropriate person's column. "**P**" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

	You	Father	Mother	Spouse	Brother (s)		Sister (s)		Children		
Age											
AIDS /HIV											
Alcohol											
Anxiety											
Arthritis											
Asthma/Hay fever /Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:_____											
Other:_____											

If any of the above family members are deceased, please list their age at death and cause.

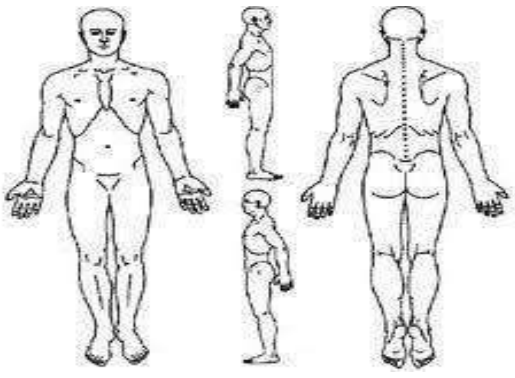
_____

MUSCULOSKELETAL

☐ Muscle Cramps –Where? ☐ Muscle pain /rheumatism _ Where? ☐ Arthritis – Where?

☐ Joint Swelling –Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

Please mark problem area on diagram:



Describe Pain and Location

☐ Sharp ☐ Burning ☐ Aching ☐ Fixed ☐ Other: _____

☐ Sharp ☐ Burning ☐ Aching ☐ Fixed ☐ Other: _____

☐ Sharp ☐ Burning ☐ Aching ☐ Fixed ☐ Other: _____

Acupuncture
Informed Consent

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Acupuncture, acupressure, Moxa, cupping therapy, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be constructed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you CONSULT YOUR PHYSICIAN for any serious conditions and receive at least two medical options. It is your right and responsibility for your own body.

I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or Coumadin use. Please use caution when walking with bare feet in the treatment room.

I further understand and agree to hold harmless, to indemnify and to protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

Payment Practices

HW Acupuncture & Wellness gladly accepts SOME health insurance, automobile insurance, and worker's compensation as payment. Insurance coverage depends upon your individual plan. Please call your insurance company to verify acupuncture benefits, then call HW Acupuncture & Wellness to verify it is accepted at HW Acupuncture & Wellness. In the event your insurance does not cover acupuncture, discounted charges will be collected at the time of service.

Payment Agreement

I authorize HW Acupuncture & Wellness to release any information required to process this claim to any insurance company or attorney in this case. I also authorize my insurance company or medical provider to release my medical records to HW Acupuncture & Wellness. This information is to be used for the purpose of processing my claims for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original. I hereby authorize my insurance benefits to be paid directly to HW Acupuncture & Wellness. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by HW Acupuncture & Wellness.
I agree to pay charges and services not covered by any insurance or other third-party payer and/or not paid to HW Acupuncture & Wellness for any reason within a reasonable time (as determined by HW Acupuncture & Wellness). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator, or third party responsible for payment of the charges.

Cancellation Notice

Please be considerate of your appointment time. We make every effort to respect your time and see you promptly when you are scheduled. Please call if you cannot make your appointment or you are running late. Patients who consistently miss their appointments or fail to cancel 24 hours in advance may be charged for their missed appointments.

I have read and understand the above Informed Consent statement. I agree to the conditions set forth in this statement.

Patient's Name (please print): _____

Signature of patient or legal guardian: _____ Date: _____