



**The Acupuncture Clinic
& Whole Body Therapy**
2855 E. Brown Rd., Ste. 17
Mesa, AZ 85213
(480) 641-5353

PATIENT INFORMATION

Name: (last, first, initial)		
Street Address:		
City, State, Zip:		
Mobile Phone:	Home Phone:	Work Phone:
Email:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Employers Name:		Occupation:
Spouse / Partner:		Phone:
Emergency Contact Name:		Phone:
Phone # & Address where it is okay to contact you – <i>if different from above:</i>		
Responsible Party Information: <input type="checkbox"/> Self/Same as above		Relationship to Patient:
Name: (last, first, initial)		
Street Address:		
City, State, Zip:		
Mobile Phone:	Home Phone:	Work Phone:
Email:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

*I authorize you to release information regarding my care and treatment to the following:

*You may speak to on the phone or in person regarding my care and treatment to the following:

I certify that the information provided is true and accurate. I assign any payable benefits to be paid directly to The Acupuncture Clinic & Whole Body Therapy and authorize them to submit a claim on my behalf and release any information required to obtain payment for my care and treatment.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF SERVICE.

Signature

Relationship to Patient

Date

Focus

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities (check all that apply):

- | | | | |
|----------------------------------|--|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Work | <input type="checkbox"/> Standing | <input type="checkbox"/> Sexually | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Emotionally | <input type="checkbox"/> Recreation | _____ |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Relationships | <input type="checkbox"/> Bending | _____ |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Social Life | <input type="checkbox"/> Stretching | _____ |

What have you done about this? _____

Have you had Acupuncture before? Y/N

Are there any other therapies which you are involved in? Y/N

With whom and what therapy? _____

Are you interested in:

- | | | | |
|--|---|--|--------------------------------|
| <input type="checkbox"/> Pain Relief | <input type="checkbox"/> Far Infrared Sauna | <input type="checkbox"/> Energy Balancing | <input type="checkbox"/> Other |
| <input type="checkbox"/> Stress Reduction | <input type="checkbox"/> Colorpuncture | <input type="checkbox"/> Maintenance Care | _____ |
| <input type="checkbox"/> Chinese Herbs | <input type="checkbox"/> Asian Bodywork | <input type="checkbox"/> Preventative Care | _____ |
| <input type="checkbox"/> Chinese Nutrition | <input type="checkbox"/> Cupping | <input type="checkbox"/> Performance Care | _____ |

What are your health goals? _____

List exercise and sport activities you have been or are currently involved in:

Female Concerns

Date of last menstruation _____ Is your cycle regular? Y/N Is your cycle painful? Y/N

Have you ever been pregnant? Y/N Number of times: _____ Number of live births: _____

Birth control? Y/N How long? _____ PMS Clotting Vaginal sores Vaginal pain Discharge

Age period started: _____ Date of Menopause: _____

Date of last Pap and breast exam: _____ Results normal? Y/N

Male Concerns

Date of last prostate check: _____ Urinary problems: _____

Erection difficulties: Y/N Type and for how long: _____

Signs/Symptoms

Please check all that apply:

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> Abdominal pain or distention | <input type="checkbox"/> Dark stools | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Muscle cramps, pain | <input type="checkbox"/> Redness of eyes |
| <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Seeing a therapist |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Depression | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Neck / shoulder pain | <input type="checkbox"/> Short temper |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dizziness / vertigo | <input type="checkbox"/> Impotence | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Dry throat or mouth | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Sinus pressure |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Skin fungal infection |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Earaches | <input type="checkbox"/> Intestinal cramps | <input type="checkbox"/> Numbness | <input type="checkbox"/> Spots in eyes |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Eye pain or strain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Odorous stools | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Breast lump or pain | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Itchy skin | <input type="checkbox"/> Peculiar tastes | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Fever | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Teeth / gum problems |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Gas / belching | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Goiter | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Premature graying | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Wake to urinate |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Headache | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Rash | <input type="checkbox"/> Weight loss / gain |
| | | | | <input type="checkbox"/> Wheezing |

Please indicate if you have or had any of the following conditions:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Lupus | <input type="checkbox"/> HIV / Aids |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mental breakdown | <input type="checkbox"/> Diabetes | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypo / Hyperthyroid | <input type="checkbox"/> Gout |
| <input type="checkbox"/> COPD / Emphysema | <input type="checkbox"/> Anxiety / panic | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Plantar fasciitis |
| <input type="checkbox"/> Valley fever | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Chronic UTI's | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Migraines | <input type="checkbox"/> Cystitis | <input type="checkbox"/> Other auto-immune diseases |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Enlarged prostate | _____ |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Seizures / Epilepsy | <input type="checkbox"/> GERD | _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bells Palsy | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> IBS | _____ |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Crohn's disease | _____ |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Shingles | <input type="checkbox"/> Hepatitis | _____ |

Do you sleep well? Y/N Do you dream? Y/N

Do you have a high point during the day? Y/N When? _____

Do you have a low point? Y/N When? _____

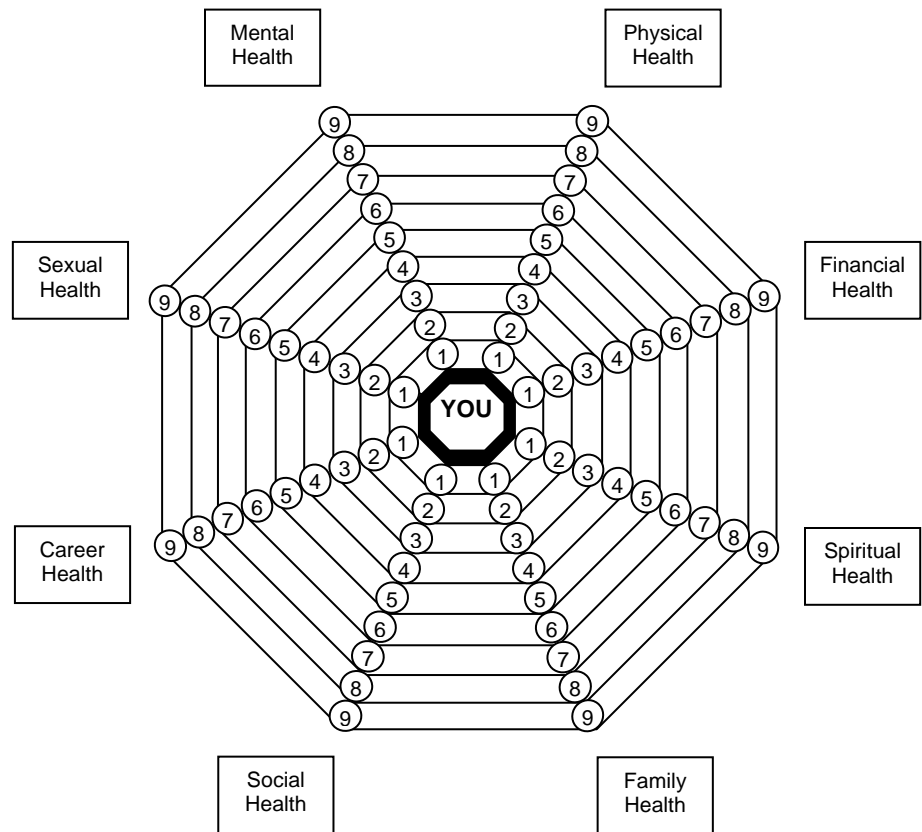
What are your indulgences?

What are your hobbies or recreational activities?

Web of Wellness

Our health and overall personal wellness are a combination of many factors. Each individual aspect of our lives can either contribute to our health and well being, or create stress, disease or illness. Using the diagram to the right, and starting at the center, choose your level of satisfaction in each area.

For example:
If you are extremely satisfied with your career, shade in the #9 circle in the career line.
1 = Not happy
9 = Extremely happy



Pain

Pain intensity levels (please indicate below which best describes)

No pain Moderate pain Severe pain Extreme pain

Sleeping

No problem Mildly disturbed Greatly disturbed Cannot sleep

Work – Capacity you are able to work at

100% 75% 50% 25% Unable to work

Frequency of pain

25% of time 50% of time 75% of time 100% of time

Travel

No problem on long trips Moderate pain on trips Severe pain

Sitting

No pain sitting Some pain while sitting Cannot sit without pain

Recreation

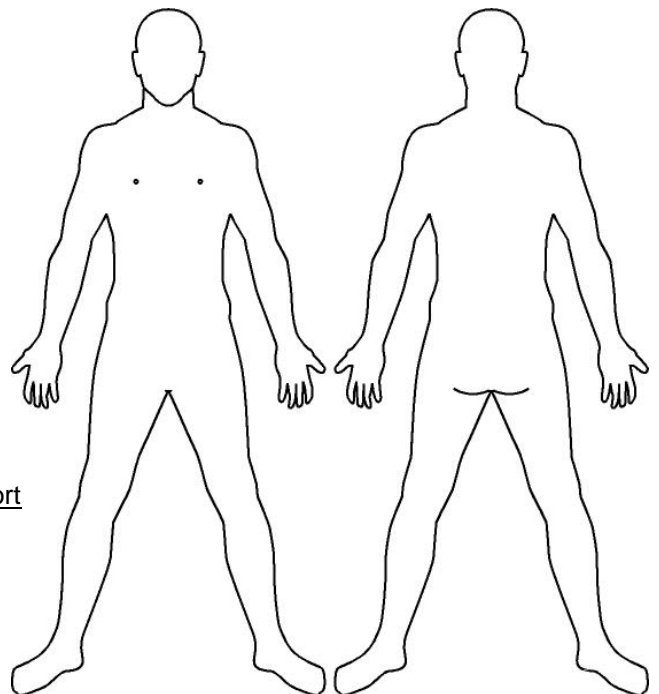
No problem Mild discomfort Moderate discomfort Severe discomfort

Walking

Can walk any distance Pain in less than 30 minutes Cannot walk

Body Chart

Please indicate areas of pain, tension, tightness, or discomfort on the body chart with 'Xs'.



Types of Care

<p>Acute Care <i>Signs and Symptoms you need Acute Care are:</i> Get me out of pain and discomfort now! I've had enough of this!</p> <p>Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms. <u>Acute Care</u> helps to ease your initial problem(s) quickly. This usually involves 1-3 treatments per week, anywhere from 6 to 12 weeks.</p>	<p>Maintenance Care <i>Your signs and symptoms lessen, now you can go to Maintenance Care:</i> You are feeling good, no big problems!</p> <p><u>Maintenance Care</u> gives you a chance for deeper healing to occur. We are strengthening your body's response to stress or illness by stimulating your natural healing powers. This phase may last anywhere from 2 to 6 months with a treatment frequency of 1 to 4 times per month.</p>	<p>Wellness & Preventative Care <i>Now you feel great, what do you do next?</i> Feeling great! Life is wonderful!</p> <p>You want to achieve optimal health and well-being, free of disease and illness. <u>Wellness Care</u> is your best choice. This phase begins after you are out of maintenance care and can be anything from monthly to seasonal treatments, depending on your situation, desired outcome or health goals.</p>
<p><u>Recommendations:</u></p> <p><input type="checkbox"/> Acute Care: _____</p> <p><input type="checkbox"/> Maintenance Care: _____</p> <p><input type="checkbox"/> Wellness & Preventative Care: _____</p>		

Terms of Acceptance

When a client seeks acupuncture health care and I accept the patient for such care, it is important for both of us to have the same goals.

Acupuncture is focused upon several objectives:

- ☉ To treat the patterns that indicate the core problems of the body, along with your symptoms by manipulating the Qi (the body's essential life force)
- ☉ To balance and enhance the body's natural ability to respond to stress, to heal itself, and to express its maximum health potential
- ☉ To continue to support the system so that it has the capacity to maintain optimal health and well-being

Stimulation of the acupuncture points is the primary method by which the bodies' energy is balanced. This is done by the insertion of sterile acupuncture needles, which facilitate the normal and balanced flow of Qi through the Meridian pathways.

I do not offer to diagnose or treat any disease or condition other than the imbalance of Qi. However, if during the course of an acupuncture treatment I encounter other findings, I will advise you. If you desire advice or other treatments regarding those findings, I will recommend that you seek the services of a health care provider best qualified to treat those problems.

Nor do I offer advice regarding treatment prescribed by others. The only practice objective is to detect and correct imbalances within the Meridian pathways using Acupuncture and Chinese medical techniques.

I, _____ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept acupuncture care on this basis.

Signature _____ Date _____

Cancellation and Late Policy

We all hate to hurry up and wait, that is why here at The Acupuncture Clinic we will do everything in our power to ensure that you are seen at your scheduled appointment time. Emergencies could possibly arise which would require our immediate attention, and we appreciate your patience during these times. Remember, the emergency could be yours at some point.

This being said, our policy here at the Clinic on being late is this: you have a scheduled time slot and you will receive your treatment during that time. Because you are late your time slot has not changed. This is to ensure that the patient after you is seen at their scheduled time and doesn't have to wait. If there is time available after your scheduled appointment and you would like to add to your treatment time, there is a charge (billed in increments of 15 minutes). So please keep in mind traffic and other events and plan accordingly to give yourself plenty of time to get here calmly and safely.

Our policy on cancellations is a minimum 24 hour courtesy notification phone call from the patient or patient representative. Keep in mind that we are closed on Sunday and a call on that day to cancel a Monday appointment will not count. Failure to give a 24 hour notice will result in a \$35.00 charge either billed to you or applied to your next appointment fee.

Acknowledgement of Receipt of Privacy Practices Notice

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of The Acupuncture Clinic & Whole Body Therapy's "Notice of Privacy Practices;" revision date 1/06/2010.

As required by the Privacy Regulations, the staff of The Acupuncture Clinic & Whole Body Therapy have explained the "Notice of Privacy Practices" to my satisfaction.

As required by the Privacy Regulations, I am aware that The Acupuncture Clinic & Whole Body Therapy has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Signature

Date

Print Name