GENERAL INFORMATION

Full Name: _____ Date of Birth: _____ ☐Male ☐Female

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Mobile _____ Email: _____

Marital Status: _____

Employer/Occupation: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Primary Physician: _____ Phone: _____ May we contact them? ☐ Y ☐N

Who referred you (How did you hear about us)? _____

PRIMARY INSURANCE INFORMATION *(health insurance, auto insurance, workers compensation, etc)*

Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

ID/Claim # (include alpha prefix): _____ Group/Policy #: _____

Name of Insured (if other than you): _____

Relationship to insured: _____ Insured's Date of Birth: _____ ☐Male ☐Female

Adjuster's name: _____ Phone: _____ Fax: _____

SECONDARY INSURANCE INFORMATION *(if you have other insurance)*

Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

ID/Claim # (include alpha prefix): _____ Group Plan/Policy #: _____

Name of Insured (if other than you): _____

Relationship to insured: _____ Insured's Date of Birth: _____ ☐Male ☐Female

Adjuster's name: _____ Phone: _____ Fax: _____

MOTOR VEHICLE ACCIDENT (MVA) *(additional information necessary if applicable - auto insurance)*

Accident occurred in what state? _____ On: date _____ time _____

Job related accident? ☐No ☐Yes

Did you report the accident to the insurance company? ☐No ☐Yes (to whom) _____

Did you submit the "Application of No-Fault Benefits" to your insurance company? ☐ No ☐Yes, date _____

Attorney Name (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

WORKERS COMPENSATION *(additional information necessary if applicable)*

SSN: _____ - _____ - _____

Have you received any bodywork treatments for this injury/claim? ☐No ☐Yes, what _____

Number of sessions: _____ Date claim opened: _____ Dates of coverage: _____

OFFICE USE ONLY

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Name: _____ DOB: _____ Sex: _____ DOS: _____

Please be advised of the policies for this office. Your signature on page 2 signifies acceptance of these policies.

COMMUNICATION/APPOINTMENT REMINDERS

The preferred method(s) of communication completed and signature on page 2 authorizes the office staff/practitioner(s) to notify you regarding your appointments or for other communications/information related to the office.

Text (mobile number): _____

Email: _____

Telephone: ☐same as mobile ☐_____

Type: ☐home ☐work ☐_____

Postal Mail: ☐same as on registration ☐_____

CANCELLATION

A 24-hour notice is required for cancellation of an appointment, or you may be charged a cancellation fee for the appointment. Payment is due before your next appointment.

We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fees.

TARDINESS

Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

SICKNESS

Bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.

FINANCIAL RESPONSIBILITY

Payment is required in full for services rendered at the time of visit, unless other arrangements have been made. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and other expenses incurred in collecting on the practitioner(s) account.

Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature on page 2 confirms your financial responsibility for all services regardless of insurance reimbursement.

ASSIGNMENT OF BENEFITS

Your signature on page 2 authorizes and directs payment of medical benefits to the practitioner(s) for services provided by this office.

RELEASE OF MEDICAL RECORDS

Your signature on page 2 authorizes the release of all of your/your child/dependents medical records on file in this office, for the purpose of processing claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

ACUPUNCTURE TERMS OF ACCEPTANCE

When a client seeks acupuncture health care and the practitioner accepts a patient for such care, it is essential for both to be working toward the same objectives.

TURN OVER

Name: _____ DOB: _____ Sex: _____ DOS: _____

Name: DOB: Sex: DOS:

Acupuncture is focused upon a few goals: to detect and correct the quality, quantity and balance of Qi, Blood and other body fluids. When done correctly, the body will have the capacity to obtain and maintain health and well-being.

It is important that each client understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Acupoint stimulation: The insertion of sterile acupuncture needles cause a specific stimulation of an acupoint. This will facilitate the normal and balanced flow of Qi through the Meridian pathways.

Health: A state of optimal physical, mental and spiritual well-being, not merely the absence of infirmity.

Qi Imbalance: When the quality, quantity and balance of Qi is disrupted, it causes illness and disease. An imbalance in any of the 14 main meridian channels causes an alteration in the flow of Qi through the entire body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Acupuncture does not offer to diagnose or treat any disease or condition other than the quality, quantity and balance of Qi. However, if during the course of an acupuncture examination the practitioner encounter non-acupuncture or unusual findings, they will advise you. If you desire advice, diagnosis or treatments of those findings, it will be recommended you seek the services of a health care provider qualified to treat those problems.

Regardless of what a disease is called, the practitioner does not offer to treat it. Nor will they offer advice regarding treatment prescribed by others. The ONLY practice objective is to detect and correct imbalances within Meridian pathways using Acupuncture and Chinese medical techniques. This can help facilitate healing and potentially lead to full expression of your body's innate wisdom.

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. My signature below authorizes said acceptance.

MASSAGE THERAPY CONSENT/AGREEMENT

I understand that massage therapy:

- does not diagnose illness or disease, or any other disorder, and that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.
- is not a substitute for medical examinations or medical care, and that it is recommended that I am concurrently working with my physician, chiropractor or other qualified medical specialist for any condition I may have.

I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there will be no liability on the part of the therapist should I fail to do so.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

It is my choice to receive massage therapy. I am aware of the risks and benefits of massage and give my consent for massage for myself or my child/dependent. My signature below authorizes said consent/agreement.

AUTHORIZING SIGNATURE

Date _____ Patient/Client/Parent/Guardian *SIGNATURE* _____

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GENERAL INFORMATION

Have you had any of the following types of health care? ☐ Acupuncture ☐ Chiropractic ☐ Massage Therapy

When was the last time you received treatment (general)? Acupuncture _____ Chiro _____ MT _____

Are you presently under a doctor's care? ☐ No ☐ Yes Who/What: _____

Are there any other therapies which you are involved? ☐ No ☐ Yes Who/What: _____

FOCUS

What is the primary reason for seeking care in our office? _____

Are you interested in: ☐ Pain relief ☐ Performance care ☐ Maintenance care ☐ Preventative care ☐ Holistic Health

☐ Stress relief ☐ Oriental nutrition ☐ Meridian yoga ☐ Herbal therapy ☐ _____

What do you hope to gain from your visit/treatment? ☐ Reduce symptoms ☐ How to prevent symptoms from occurring again

☐ Resume/Increase activity ☐ Learn how to take care of the symptoms on my own ☐ _____

What are your health goals? _____

Indicate any significant trauma and their occurrences (auto accident, falls, emotional, sexual, etc) ☐ None

_____

Indicate any exercise and sport activities you have been or are currently involved in ☐ None

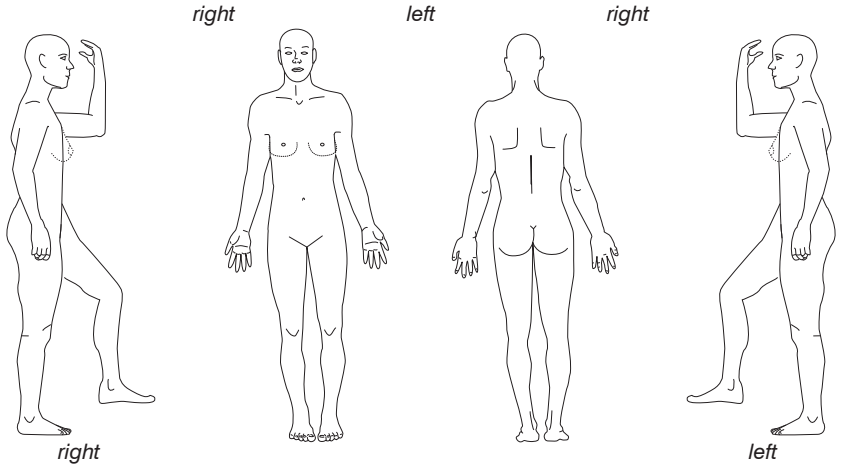
_____

SYMPTOMS & PAIN

Identify **CURRENT** symptomatic areas in your body by marking letters on the figures (right).

- Use the letters provided in the key to identify the symptoms you are feeling
- **CIRCLE** the area around each letter, representing the size and shape of each symptom location

SYMPTOM KEY
N = numbness or tingling
P = Pain
S = joint or muscle stiffness



What was the initial cause of the symptoms? _____

When did the present symptoms appear? _____

Have you ever had similar symptoms in the past? ☐ No ☐ Yes

Explain: _____

Who did you receive treatment from? _____

How often do you experience them during the day? ☐ Intermittent *(0-25%)* ☐ Occasional *(26-50%)* ☐ Frequent *(51-75%)* ☐ Constant *(76-100%)*

Describe the nature of your symptoms? ☐ Sharp ☐ Shooting ☐ Dull Ache ☐ Burning ☐ Numb ☐ Tingling ☐ _____

How are your symptoms changing? ☐ Improving ☐ Same ☐ Getting worse

What makes your symptoms worse? _____

What makes your symptoms better? _____

What activities do your symptoms interfere with? ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Standing ☐ Bending ☐ Stretching

☐ Emotional ☐ Relationships ☐ Social Life ☐ Sexually ☐ Recreationally ☐ _____

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Name: _____ DOB: _____ Sex: _____ DOS: _____

Name: DOB: Sex: DOS:

Have your seen or are you seeing anyone else for your symptoms? ☐No ☐Yes

Type of provider _____ When _____ Treatment _____

Have you had any tests for your symptoms? ☐No ☐Yes

☐Xrays (date _____) ☐CT Scan (date _____) ☐MRI (date _____) ☐ _____

RATING SCALE (1-10, 1 being nothing and 10 being most severe)

Symptoms at their worst: **1 2 3 4 5 6 7 8 9 10** Symptoms at their best: **1 2 3 4 5 6 7 8 9 10**

How symptoms affect your ability to perform daily activities: **1 2 3 4 5 6 7 8 9 10**

Pain level TODAY: **1 2 3 4 5 6 7 8 9 10**

MEDICAL HISTORY

Allergies: ☐None _____

Medications *(including over-the-counter and herbal/supplements)* ☐None

name	*reason for taking*	*name*	*reason for taking*

Indicate any relevant surgical procedures and their dates (past and future) ☐None

SIGNS/SYMPTOMS/CONDITIONS *(P = past, C = current)*

P	C		P	C		P	C		P	C		P	C	
☐	☐	Abdominal pain/distension	☐	☐	Degenerative disk/spine	☐	☐	Hip/Upper leg pain	☐	☐	Muscle cramps/pain	☐	☐	Shortness of breath
☐	☐	Abuse survivor	☐	☐	Depression	☐	☐	HIV/AIDS	☐	☐	Muscular incoordination	☐	☐	Sinus pressure
☐	☐	Acid regurgitation	☐	☐	Diabetes	☐	☐	Impotence	☐	☐	Nasal congestion	☐	☐	Sinusitis, chronic
☐	☐	Acne	☐	☐	Diarrhea	☐	☐	Increased libido	☐	☐	Neck/Shoulder pain	☐	☐	Skin fungal infection
☐	☐	Anemia	☐	☐	Digestive conditions	☐	☐	Indigestion	☐	☐	Neurological disorders	☐	☐	Smoking/Tobacco use
☐	☐	Angina	☐	☐	Dizziness/vertigo	☐	☐	Infection	☐	☐	Night sweat	☐	☐	Spots in eyes
☐	☐	Appetite loss	☐	☐	Drug/Alcohol dependence	☐	☐	Intestinal pain/cramps	☐	☐	Nocturnal emission	☐	☐	Sore throat
☐	☐	Arthritis	☐	☐	Dry mouth/throat	☐	☐	Irritable	☐	☐	Nose bleeds	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Ear aches	☐	☐	Irregular menstrual cycle	☐	☐	Numbness/Tingling	☐	☐	Sudden energy drop
☐	☐	Bad breath	☐	☐	Elbow/Upper arm pain	☐	☐	Itchy eyes	☐	☐	Odorous stools	☐	☐	Sweat easily
☐	☐	Bladder infection/UTI	☐	☐	Enlarged thyroid	☐	☐	Itchy skin	☐	☐	Osteoporosis	☐	☐	Swelling
☐	☐	Blood clots	☐	☐	Epilepsy/Seizures	☐	☐	Jaw pain	☐	☐	Pain upon urination	☐	☐	Swollen glands
☐	☐	Blood in stool	☐	☐	Excessive phlegm	☐	☐	Joint pain	☐	☐	Painful menstrual cycle	☐	☐	Teeth/Gum problem
☐	☐	Blood in urine	☐	☐	Excessive saliva	☐	☐	Joint swelling/stiffness	☐	☐	Peculiar tastes	☐	☐	Tumor
☐	☐	Blurry vision	☐	☐	Eye pain/strain/tension	☐	☐	Kidney disorders	☐	☐	Pitted edema	☐	☐	Ulcers
☐	☐	Breast lump/pain	☐	☐	Fatigue	☐	☐	Kidney stones	☐	☐	PMS	☐	☐	Ulcerations
☐	☐	Broken bones	☐	☐	Fever	☐	☐	Knee/Lower leg pain	☐	☐	Poor appetite	☐	☐	Upper back pain
☐	☐	Bruise easily	☐	☐	Frequent urination	☐	☐	Laxative use	☐	☐	Poor circulation	☐	☐	Urgent urination
☐	☐	Cancer	☐	☐	Gas/Belching	☐	☐	Limited range of motion	☐	☐	Poor memory	☐	☐	Vaginal clotting
☐	☐	Chest pain	☐	☐	Gout	☐	☐	Liver/gallbladder disorder	☐	☐	Poor sleep	☐	☐	Vaginal discharge
☐	☐	Chills	☐	☐	Grinding Teeth	☐	☐	Loss of hair	☐	☐	Pregnancy	☐	☐	Vaginal pain
☐	☐	Cold hands/feet	☐	☐	Hand pain	☐	☐	Low back pain	☐	☐	Premature ejaculation	☐	☐	Vaginal sores
☐	☐	Concussion	☐	☐	Headache	☐	☐	Low blood pressure	☐	☐	Prostate problems	☐	☐	Varicose veins
☐	☐	Confusion	☐	☐	Hemorrhoids	☐	☐	Lupus, systemic	☐	☐	Psoriasis	☐	☐	Visual disturbances
☐	☐	Congestive heart failure	☐	☐	Heart attack	☐	☐	Mental Illness	☐	☐	Rash/dermatitis/eczema	☐	☐	Vomiting
☐	☐	Constipation	☐	☐	Heart palpitations	☐	☐	Mid back pain	☐	☐	Redness of eyes	☐	☐	Wake to urination
☐	☐	Cough	☐	☐	Hepatitis	☐	☐	Migraine	☐	☐	Rheumatoid arthritis	☐	☐	Weigh loss/gain
☐	☐	Coughing blood	☐	☐	Hiccup	☐	☐	Mouth sores	☐	☐	Scoliosis	☐	☐	Wheezing
☐	☐	Dark stools	☐	☐	High blood pressure	☐	☐	Mucous in stool	☐	☐	Short temper	☐	☐	Wrist pain
☐	☐	Decreased libido												

ADDITIONAL PROVIDER COMMENTS

_____

_____

_____

_____

_____

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