



Acu-Na Wellness Center

Today's Date _____ / _____ / _____

Welcome and congratulations for taking TIME for YOURSELF!

Confidential Client Information

I will be evaluating many factors from your past medical history as well as from your present medical condition. By filling out this form in the most complete manner possible, you will greatly assist me in understanding and discovering underlying factors that may be adversely affecting your health.

This is a **CONFIDENTIAL** questionnaire to help me determine the best treatment plan for you. If you have any questions, please ask.

Name	Date of Birth	Age
Address	Height	Weight
City	State	Zip
Home Phone	Marital Status	
Work Phone	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Mobile Phone	Fax	
Current Occupation/Length of time:	Driver License # (require for us to accept any checks)	
Your Website (if applicable) Are you on Facebook? Y / N	Email Address (required to receive special online savings)	
Please check the forms of complementary medicine that you have used. Briefly describe your results and experience. <input type="checkbox"/> acupuncture, <input type="checkbox"/> massage, <input type="checkbox"/> chiropractic, <input type="checkbox"/> herbs, <input type="checkbox"/> homeopathy, <input type="checkbox"/> nutritional program, <input type="checkbox"/> detoxification program		How did you hear about us?
Our Wellness Center offers many services. Please check the services you may be interested in. <input type="checkbox"/> acupuncture, <input type="checkbox"/> massage, <input type="checkbox"/> natural medicine approach to health, <input type="checkbox"/> herbs, <input type="checkbox"/> FirstLine Therapeutic Lifestyle Program, <input type="checkbox"/> nutritional counseling, <input type="checkbox"/> detoxification program, <input type="checkbox"/> weight loss, <input type="checkbox"/> assistance to reduce reliance on medication, <input type="checkbox"/> hormone balancing Non Pharmaceutical approach to chronic conditions such as: <input type="checkbox"/> diabetes, <input type="checkbox"/> heart disease, <input type="checkbox"/> abdominal weight gain, <input type="checkbox"/> menopausal symptoms, <input type="checkbox"/> pain, <input type="checkbox"/> acid reflux, <input type="checkbox"/> other (please enter)		Previous Occupations of any significant length:

Please check the forms of complementary medicine that you have used. Briefly describe your results and experience.
 acupuncture, massage, chiropractic, herbs, homeopathy, nutritional program, detoxification program

Our Wellness Center offers many services. Please check the services you may be interested in.

acupuncture, massage, natural medicine approach to health, herbs, FirstLine Therapeutic Lifestyle Program, nutritional counseling, detoxification program, weight loss, assistance to reduce reliance on medication, hormone balancing

Non Pharmaceutical approach to chronic conditions such as:
 diabetes, heart disease, abdominal weight gain, menopausal symptoms, pain, acid reflux, other (please enter)

Enter Reason for Visit Today -

How long have you had this condition?

What seemed to be the initial cause?

What are you currently doing for your condition?

What makes it better? cold heat pressure movement rest

Is it getting worse?

What makes it worse? cold heat pressure movement rest

Any recent injury or illness?

List any significant past traumas or accidents or significant childhood illnesses?

List any surgeries and dates:

INITIAL _____

Are you under a doctor's care?	If yes, for what?
Who is your Physician? Where are they located?	Physician's Phone # Name of their Clinic

Is your physician supportive of complementary medicine? How do you know?

Medical History Check any condition that applies to you.			
<input type="checkbox"/> Abdominal Discomfort <input type="checkbox"/> Addiction(s) <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Allergies <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic Disease <input type="checkbox"/> Clotting or Bleeding <input type="checkbox"/> Contacts <input type="checkbox"/> Contagious Condition <input type="checkbox"/> Diabetes <input type="checkbox"/> Disc. Problems	<input type="checkbox"/> Dizziness <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Emotional condition <input type="checkbox"/> Exercise regularly <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Herpes <input type="checkbox"/> High/Low BP <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Numbness <input type="checkbox"/> Pacemaker	<input type="checkbox"/> Pain _____ <input type="checkbox"/> Phlebitis/Varicose Veins <input type="checkbox"/> Scoliosis <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Skin Condition <input type="checkbox"/> Sleep Problem <input type="checkbox"/> Stress <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid (hypo/hyper) <input type="checkbox"/> Tumor <input type="checkbox"/> Other _____ <input type="checkbox"/> Any other diagnosis _____	<p>Do you currently use:</p> <input type="checkbox"/> Alcohol <input type="checkbox"/> Caffeine <input type="checkbox"/> Tobacco <input type="checkbox"/> Recreational Drugs <p>How often used? _____</p>

For Women: Please check all that apply	For Men: Please check all that apply:
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what month are you due? _____ Are you still menstruating? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the last date of your last cycle? _____ <input type="checkbox"/> Chronic Yeast Infections <input type="checkbox"/> Ovarian Cancer <input type="checkbox"/> Endometriosis <input type="checkbox"/> Hysterectomy: when _____	<input type="checkbox"/> Urinary Difficulty <input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Testicular Pain <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Breast enlargement <input type="checkbox"/> Low libido <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Decrease strength <input type="checkbox"/> Decrease muscle mass

Family Medical History

Check Those Applicable	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)						
Health G = Good P = Poor						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, Hayfever, Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Age (at death)						
Cause of death						

INITIAL _____

Confidentiality

Client confidentiality is maintained, exceptions include requirements by law, court order, or with client consent.

Emergency Contact Information

Please list person or persons whom we may inform about your medical condition ONLY IN AN EMERGENCY.

_____ Name

_____ Phone

_____ Name

_____ Phone

Please print the telephone number(s) where you want to receive calls

Check One

____ Okay to leave message with detailed information ____ Leave message with callback number only

Newsletters and On-Line Discounts

____ **Yes I would like to receive your newsletters and promotions by email @**

Financial Policy:

Payment is due at the time of each visit. There is a \$35 fee for returned checks. ____ Initial

Insurance Policy

Every insurance policy is different therefore we do not bill or take insurance. There is no guarantee your insurance company will pay for our services. We will provide you with a receipt for therapeutic services provided. You may then submit this receipt along with a claim for reimbursement to your insurance company. ____ Initial

Appointment Time and Length

We make every attempt to stay on schedule. Please arrive 15- 20 minutes prior to your first appointment to complete necessary paperwork. **Your schedule session time includes your dress and undress time and any dialogue/counselation pertaining to you or your treatment.** We make every effort to stay on schedule as we respect the value of your time. ____ Initial

Cancellation Policy

The time of your appointment is reserved for *you*. Please give 24-hour notice if you are unable to keep your appointment. If you do not cancel your appointment according to cancellation policy, you will be charged the amount of time reserved for you. Emergencies will be handled on a case by case basis. ____ Initial

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**North Carolina Acupuncture Licensing Board
§ 90-451. Definitions**

Practice of Acupuncture. A form of health care developed from traditional and modern Chinese medical concepts that employ acupuncture diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease. Practice of acupuncture or practice acupuncture – The insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based upon acupuncture diagnosis as a primary mode of therapy. ADJUNCTIVE therapies within the scope of acupuncture may include massage, mechanical, thermal, electrical and electromagnetic treatment and the recommendation of herbs, dietary guidelines, and therapeutic exercise.

By signing below, I acknowledge the following:

- I have honestly and comprehensively answered the above questions.
- I have stated all my medical conditions and will keep my massage practitioner updated on my health.
- It is the responsibility of the patient to notify Acu-na Wellness Center if any information provided in this document changes
- If at anytime during the massage I feel uncomfortable and/or wish my practitioner to adjust pressure, draping, or room temperature etc, I will tell them so.
- I recognize and understand my responsibilities as a client
- I understand the scope of practice of an acupuncturist
- I fully understand the information presented and voluntarily consent to treatment.
- I understand that there is not a guarantee or an implied guarantee about the success of treatment given.

Print Name of Client

_____ (guardian if under 18 yrs)
Print Name of Guardian

 X

Signature of Client or Guardian

Date

**THANK YOU FOR YOUR PATIENCE, COOPERATION, AND
FOR CHOOSING ACU-NA WELLNESS CENTER**

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