Acu-Na Wellness Center

Welcome and congratulations for taking TIME for YOURSELF!

We are a full service Wellness Center.
Therefore, we appreciate your time in providing the following information, as it will **help us determine how to best serve you**. It will help us discover underlying factors that may be adversely affecting your health.
This is a **CONFIDENTIAL** questionnaire to help us determine the best treatment plan for you.
If you have any questions, please ask.

Today's Date _____ /_____ / _____

Name	Date of Birth Age
Address	Height Weight
City State Zip	Marital Status
Home Phone	Sex: ❑ Male ❑ Female
Work Phone	Current Occupation/Length of time:
Mobile Phone	Driver License # (required for us to accept any checks)
Emergency Contact Information Name_____Phone #_____	Are you on Facebook? Yes / No If so, please consider "Liking" Our Facebook Page!
How did you hear about us? ☐Google Search ☐Yelp/Tripadvisor ☐Advertisement ☐Referral from_____ ☐Event ☐ Other (please specify)	**Email Address** _____ Are you willing to receive discounts, special offers, and newsletters by email? Yes/ No

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 all of the services you may be interested in.

☐ acupuncture, ☐ massage, ☐ natural medicine approach to health, ☐ herbs, ☐ First Line 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)

What is the Reason for your Visit today?

How long have you had this condition?
What seemed to be the initial cause?
If you have been diagnosed, what is the diagnosis?
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, accidents, or significant childhood illnesses:	
List any surgeries or hospitalizations with dates:	
Are you under a doctor's care? Yes/No	Have you received a diagnosis? If so, please describe?
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.

❑ Abdominal Discomfort ❑ Addiction(s) ❑ AIDS/HIV ❑ Allergies ❑ Anxiety ❑ Arthritis ❑ Asthma ❑ Cancer ❑ Chronic Disease ❑ Clotting or Bleeding ❑ Contacts ❑ Contagious Condition ❑ Diabetes ❑ Disc Problems ❑ Dizziness	❑ Eating Disorder ❑ Emotional condition ❑ Exercise regularly ❑ Fibromyalgia ❑ Headaches ❑ Heart Disease ❑ Hepatitis ❑ Herpes ❑ High/Low BP ❑ Infectious Disease ❑ Multiple Sclerosis ❑ Numbness ❑ Pacemaker ❑ Artificial Joints ❑ Pain_____	❑ Phlebitis/Varicose Veins ❑ Scoliosis ❑ Seizures/Epilepsy ❑ Sinus Congestion ❑ Skin Condition ❑ Sleep Problem ❑ Stress ❑ Stroke ❑ Thyroid (Hypo/Hyper?) ❑ Tumor ❑ Constipation ❑ Diarrhea ❑ Other _____ ❑ Any other diagnosis _____	**Do you currently use:** ❑ Alcohol ❑ Caffeine ❑ Tobacco ❑ Recreational Drugs **How often used?** _____

For Women: Please check all that apply:	**For Men:** Please check all that apply:
Could you be pregnant? ❑ Yes ❑ No If so, what month are you due? _____ Are you still menstruating? ❑ Yes ❑ No What was the last date of your last cycle? _____ ❑ Heavy/Painful Periods ❑ Chronic Yeast Infections ❑ Ovarian Cancer ❑ Endometriosis ❑ Hysterectomy: when?	❑ Urinary Difficulty ❑ Enlarged Prostate ❑ Testicular Pain ❑ Erectile Dysfunction ❑ Breast enlargement ❑ Low libido ❑ Premature ejaculation ❑ Decreased strength ❑ Decreased muscle mass

Please list any current special diets or exercise programs. _____

_____

_____

_____

All Allergies (Drugs, Chemicals, Food, Others) _____

_____

_____

_____

Family Medical History	**Father**	**Mother**	**Brothers**	**Sisters**	**Spouse**	**Child**
Age if living OR Age at Death						
Health G = Good P = Poor						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, Hayfever, Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Cause of death						

Current Medications & Supplements

Please list all prescription medicines and over-the counter supplements you use, the reason for their use, etc):

EXAMPLE

Name of Prescription or Supplement	*Reason you take it*	*Dose*	*Doses per day*	*How Long*	*Who Prescribed*
Lipitor	**High Cholesterol**	**500mg**	**1x**	**1 year**	**(Dr. or Self)**

Lab Results

Please provide approximate. date of each abnormal lab test, x-ray, MRI, biopsy, Electrocardiogram (EKG), Electroencephalogram (EEG), etc. If there was an abnormality that occurred far in the past, please write it down. Use a separate piece of paper if necessary.

_____

_____

_____

_____

_____

Please Read and Initial to Agree to our Business Policies:

Financial Policy:
Payment is due at the time of each visit. There is a $35 fee for returned checks. _____ Initial

Insurance Policy
Our office does not bill insurance. Upon request, we will provide a receipt that you may submit to your insurance company for reimbursement. We cannot guarantee your insurance company will pay for our services. _____ Initial

Appointment Time and Length
We make every effort to stay on schedule as we respect the value of your time. Please arrive 15- 20 minutes prior to your first appointment to complete necessary paperwork. **Your scheduled session time includes your dress and undress time and any dialogue/consultation pertaining to you or your treatment.** If you arrive late to your session, we cannot guarantee that you will receive a full session. _____ 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 cancel your appointment with less than 24-hour notice, you will be charged for the amount of time reserved for you**. Emergencies will be handled on a case by case basis. _____ Initial

NOTICE OF PRIVACY POLICIES
We are committed to protecting your privacy. Per HIPPA laws, we must inform you that we keep on file non-public personal information such as: your patient record, including diagnostic information and the care and services you receive, your medical history, treatment notes, test results, any letters, emails, or correspondence to our office, and records of your financial transactions.

You have rights when it comes to your health information. Your rights include the option to:
-Get a copy of your medical records upon written request. You may also request changes to your medical record if you feel it is incorrect or incomplete.
-Ask us to limit what we use or share, and get a list of those with whom we have shared any information.
-Request confidential communications, or choose someone to act for you.
-Get a copy of this privacy notice
-File a complaint with the U.S. Department of Health and Human Services Office for Civil Rights if you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

Disclosure of Information. How we use your information: We may share limited information for treatment, payment, and healthcare operations in order to best serve you. We will NEVER share or sell your information for marketing purposes. We may share your information for the following reasons:
-To treat you. To improve your care, we may share information with other professionals who are treating you.
-To run our office. We may use your information to provide your services and contact you when necessary.
-To comply with the law. We may share your information in order to comply with the requirements of state or federal law, law enforcement and government requests, and to respond to lawsuits and legal actions.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will promptly inform you if a breach occurs that may have compromised the security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it for review. We will not share or use your information other than as described here unless you give written permission to do so. If you give permission to share your information, you can change your mind any time. Let us know in writing if you change your mind.

North Carolina Acupuncture Licensing Board
§ 90-451. Definitions

Scope of Practice of Acupuncture. A form of health care developed from traditional and modern Chinese medical concepts that employ acupuncture diagnosis and treatment, and adjuctive 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. ADJUCTIVE 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 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 session 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 treatments given.

_____
Print Name of Client

(If Client is under 18 years old, **Print** Name of Guardian)_____

_____ _____
Signature of Client or Guardian Date

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

Acu-Na Wellness Center

Consent Form

I hereby request and consent to the performance of treatments and other procedures within the NC "**scope of practice of acupuncture**" on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed practitioners who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na massage, Oriental herbal medicine, and nutritional counseling.

I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

Patient Signature or Patient Representative Date
(Indicate relationship if signing for patient)

_____

Office Signature Date