



Thank you for including us in your health care decisions. The following forms help us gather important information so we can begin your care right away. All provided information is strictly confidential.

Patient Information	Contact Information
Today's Date: _____ / _____ / _____ Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Date of Birth: ____ / ____ / ____ Age: _____ Soc. Sec # _____ Occupation: _____ Employer: _____	Preferred Phone: _____ <i>May we leave a message at the number above? Y/N</i> Email: _____ <i>We will never spam, sell, or distribute your email.</i> Emergency Contact: _____ Phone: _____ Relation: _____ How did you find us? Please help us reach others! _____ May we connect with you via social media such as: <input type="checkbox"/> Twitter <input type="checkbox"/> Facebook <input type="checkbox"/> Google+ <input type="checkbox"/> Instagram

Focus of Visit
What is your primary reason for your visit? _____ What was the cause of this condition? _____ When did it start? _____ What makes it better? _____ What makes it worse? _____

Privacy Policy
I have received and reviewed the <a href="#">privacy policy/HIPPA guidelines for this practice</a> . I understand that my personal information is protected and will not be shared without my written consent. I also acknowledge that a copy of this policy will be provided to me upon request.  Signature: _____ Date: _____

## Insurance Information

*This information can be obtained by calling the number on the back of your insurance card.*

Company: \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

Member/Policy ID #: \_\_\_\_\_ Group# \_\_\_\_\_ Plan Name: \_\_\_\_\_

*For insurance purposes, are you listed as a dependent? Y/ N If yes, please provide the following:*

Primary Insured Name:: \_\_\_\_\_ Date of birth:: \_\_\_\_\_ Policy # \_\_\_\_\_

## Acupuncture Coverage

Co-Ins/Co-Pay: \_\_\_\_\_

Deductible: In Net: \_\_\_\_\_ of \_\_\_\_\_ // Out of Net: \_\_\_\_\_ of \_\_\_\_\_

Visit/Benefit Limits: \_\_\_\_\_

## Chiropractic Coverage

Co-Ins/Co-Pay: \_\_\_\_\_

Deductible: In Net: \_\_\_\_\_ of \_\_\_\_\_ // Out of Net: \_\_\_\_\_ of \_\_\_\_\_

Visit/Benefit Limits: \_\_\_\_\_

Date Contacted: \_\_\_\_\_ Rep Name: \_\_\_\_\_

Notes: \_\_\_\_\_

## Medical History

Do you have environmental allergies? Y/N To what: \_\_\_\_\_ Low/Med/High/Extreme

Do you have food allergies? Y/N To what: \_\_\_\_\_ Low/Med/High/Extreme

What medication do you take? (Dosage/**Purpose?**)

What supplements do you take? (Dosage/**Purpose?**)

1. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

4. \_\_\_\_\_

Do you notice any negative side effects from your prescribed medication or supplements? Y/N

List side effects \_\_\_\_\_

Please list all surgeries & dates: \_\_\_\_\_

## TCM Medical History

Have you ever received any of the following TCM therapies:

**Acupuncture:** Y/N    **Herbal Medicine:** Y/N    **Cupping:** Y/N    **TuiNa:** Y/N    **QiGong:** Y/N

If yes, when? (Approx dates): \_\_\_\_\_ By whom/where? \_\_\_\_\_

Medical Signs/Symptoms				
<input type="radio"/> Abdominal pain	<input type="radio"/> Dark stools	<input type="radio"/> Heart palpitations	<input type="radio"/> Muscle cramps/pain	<input type="radio"/> Short temper
<input type="radio"/> Abuse survivor	<input type="radio"/> Decreased libido	<input type="radio"/> Hiccough	<input type="radio"/> Nasal congestion	<input type="radio"/> Shortness of breath
<input type="radio"/> Acid reflux	<input type="radio"/> Depression	<input type="radio"/> High blood-pressure	<input type="radio"/> Neck/shoulder pain	<input type="radio"/> Sinus pressure
<input type="radio"/> Acne	<input type="radio"/> Dizziness/vertigo	<input type="radio"/> Impotence	<input type="radio"/> Night sweats	<input type="radio"/> Skin infection
<input type="radio"/> Asthma	<input type="radio"/> Dry mouth/throat	<input type="radio"/> Increased libido	<input type="radio"/> Nocturnal emission	<input type="radio"/> Smells/body odor
<input type="radio"/> Bad breath	<input type="radio"/> Diarrhea	<input type="radio"/> Indigestion	<input type="radio"/> Nosebleeds	<input type="radio"/> Spots in eyes
<input type="radio"/> Blood in stools	<input type="radio"/> Ear aches	<input type="radio"/> Intestinal pain	<input type="radio"/> Numbness	<input type="radio"/> Sweat easily
<input type="radio"/> Blood in urine	<input type="radio"/> Enlarged thyroid	<input type="radio"/> Irritable	<input type="radio"/> Odorous stools	<input type="radio"/> Sore throat
<input type="radio"/> Blurry vision	<input type="radio"/> Eye pain/strain	<input type="radio"/> Itchy eyes	<input type="radio"/> Painful urination	<input type="radio"/> Sudden energy drop
<input type="radio"/> Breast lump/pain	<input type="radio"/> Excess phlegm	<input type="radio"/> Itchy skin	<input type="radio"/> Peculiar tastes	<input type="radio"/> Swollen glands
<input type="radio"/> Bruise easily	<i>Color:_____</i>	<input type="radio"/> Joint pain	<input type="radio"/> Poor appetite	<input type="radio"/> Teeth/gum problem
<input type="radio"/> Chest pains	<input type="radio"/> Excessive saliva	<input type="radio"/> Kidney stones	<input type="radio"/> Poor circulation	<input type="radio"/> Upper back pain
<input type="radio"/> Chills	<input type="radio"/> Fatigue	<input type="radio"/> Laxative use	<input type="radio"/> Poor memory	<input type="radio"/> Urgent urination
<input type="radio"/> Cold hands/feet	<input type="radio"/> Fever	<input type="radio"/> Limtd range of motion	<input type="radio"/> Poor sleep	<input type="radio"/> Vomiting
<input type="radio"/> Concussion	<input type="radio"/> Frequent urination	<input type="radio"/> Loss of hair	<input type="radio"/> Psoriasis	<input type="radio"/> Wake to urinate
<input type="radio"/> Cancer:_____	<input type="radio"/> Gas/bloating	<input type="radio"/> Low back pain	<input type="radio"/> Rash	<input type="radio"/> Weight loss
<input type="radio"/> Constipation	<input type="radio"/> Grinding teeth	<input type="radio"/> Migraines	<input type="radio"/> Red eyes	<input type="radio"/> Weight gain
<input type="radio"/> Cough	<input type="radio"/> Headache	<input type="radio"/> Mouth sores/ulcers	<input type="radio"/> Seizures	<input type="radio"/> Wheezing
<input type="radio"/> Coughing blood	<input type="radio"/> Hemorrhoids	<input type="radio"/> Mucus in stool	<input type="radio"/> Therapy/counseling	

Women's Health	
Date of last menstruation: _____	Is your cycle regular? Y/N Days between periods: _____
Is your period painful? Y/N	<input type="checkbox"/> PMS <input type="checkbox"/> Cramps <input type="checkbox"/> Mood swing <input type="checkbox"/> Emotional <input type="checkbox"/> STDs _____
How long does your period last? _____ days;	Clotting? Y/N If yes, approx. size _____mm
Birth control? Y/N Type/Brand: _____	How long? _____

Men's Health	
Are you experiencing any of the following?	<input type="checkbox"/> Testicular pain/swelling <input type="checkbox"/> Prostatitis
<input type="checkbox"/> Difficulty start/stop urination	<input type="checkbox"/> Discharge/sores <input type="checkbox"/> Erectile difficulty
<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Painful urination <input type="checkbox"/> STDs _____
Other:	

**Pain (If applicable)**

Please indicate the areas of pain/tightness/discomfort on the chart.

**Pain intensity levels:**

None    Moderate    Severe    Terrible

**Frequency of Pain?**

25% of time    50%    75%    Constant

**How much work can you perform?**

Usual work    25%    50%    75%    No work

**Does this pain affect your sleep?**

No    Mildly    Greatly    Cannot Sleep

Please describe how the pain feels.  
(Sharp/dull/achy/hollow etc.)

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When did you first experience this pain?

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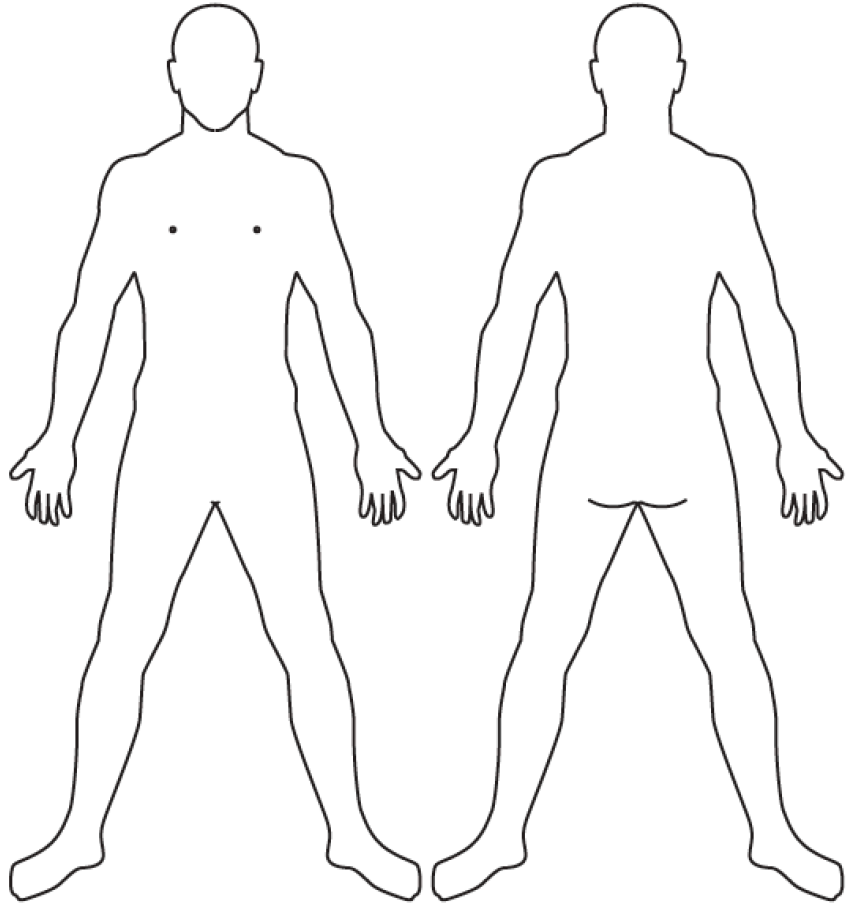
How has the pain changed since that time?

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FRONT

BACK



Practitioner notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Sun Wellness – Holistic Healthcare

## Informed Consent to Treat

I hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture and traditional Asian medicine. Methods of treatment may include, but are not limited to, acupuncture, massage, moxibustion, cupping, electrical stimulation, gua sha, herbal therapy, and nutritional consultations.

I am hereby informed that the aforementioned treatment methods are all generally safe but, as with any medically related treatment or procedure, there may be some side effects or risks, but not limited to, the following:

- ♦ Acupuncture may cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection. Potential risks of moxibustion include blistering, burns, and scarring. Common side effect of cupping and gua sha are temporary bruising and redness lasting up to 10 days.
- ♦ The herbal and nutritional supplements recommended to me are generally safe in the traditionally recommended doses. Examples of possible side effects of herbal and nutritional supplements include nausea, gas, stomach ache, diarrhea, and headache. Examples of unusual side effects of herbs include vomiting, rashes or hives. I understand I must stop taking any herbal and nutritional supplements and notify my acupuncturist if I experience any discomfort or adverse reaction.
- ♦ I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.
- ♦ I understand that I can discuss risks and benefits further before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on my practitioner to exercise their judgment in my best interest during the course of treatment based upon the facts then known.
- ♦ I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.
- ♦ I understand that my practitioner will keep all of my records confidential.

The Georgia Code 360-6-16 states that an acupuncturist is not allowed to make a medical diagnosis of a person's disease. If you are seeking to obtain a medical diagnosis, then you should seek a licensed physician and obtain medical advice from a licensed physician.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment; healthcare operations received, incurred or carried out by my practitioner.

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Printed Name of Patient or Responsible Party

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Current Date

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Signature of Patient or Responsible Party



**PLEASE READ THIS PAGE THOROUGHLY**

Clinic Appointments

We respect your time and the energy you put into managing your health care. We will always do our absolute best to provide attentive treatment in a timely manner after you arrive at the clinic.

Please help us offer this to you and other patients by arriving **on time** for your scheduled appointment. Patients who arrive more than 10 minutes late may be asked to reschedule.

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Cancellations

**We have a strict cancellation policy. If you need to cancel please call provide 24 hours notice.**

*We reserve the right to charge our **full fee** for appointments cancelled with less than twenty-four hours notice or for “no show” appointments.*

We are often waitlisted. Please help us see everyone in need by showing up on time to your appointment or providing adequate notice for others to take your appointment.

**If you need to change your appointment please call us as soon as possible.**

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Payment for Services Rendered

Payment is due at the time of service and may be paid in cash, check or credit card.

All returned checks are subject to an additional \$35 charge.

**To help keep costs low we prefer payment via check, cash or debit card.**

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**Patient signature or Responsible Party (required)**

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**Date**

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**Patient's printed name**