ACUPUNCTURE

NEW CONFIDENTIAL PATIENT INFORMATION SHEET

PATIENT INFORMATION

Name: _____

Height _____Weight _____Age _____Sex: _ Male _ Female

Date of birth: _____Marital Status: _____

MEDICAL COMPLAINT

Reason for your visit here today:

_____

_____

_____

How long have you had this condition? _____

Have/are you being treated for this condition by another healthcare practitioner? _ Yes _ No

Has this condition been diagnosed by a MD? _ Yes (Diagnosis: _____) _ No

Have these treatments helped? _ Yes _ Somewhat _ Not much _ Not at all

Have you had acupuncture before? _ Yes _ No

Do you currently have any infectious diseases? _ Yes _ No _ Possibly

If yes, please identify: _____

MEDICAL HISTORY

Please check all that apply:

Cardiovascular Conditions:
_ Heart Disease
_ Heart Attack
_ A Pacemaker
_ High Blood Pressure
_ Low Blood Pressure
_ Chest Pain
_ Palpitations
_ Stroke
_ Varicose Veins
_ Edema

Emotional / Mental:
_ Anxiety / Fear
_ Anger / Frustration
_ Grief / Sadness
_ Lack of Joy / Mania
_ Worry / Over-thinking
_ Clinical Depression
_ Mild Depression
_ ADD or ADHD
_ Panic Attacks
_ Alzheimer's
_ Dementia

Energy & Immunity:
_ General Fatigue
_ Slow Wound Healing
_ Easy Bruising
_ Chronic Infections
_ Frequent Allergies

Endocrine:
_ Hypothyroid
_ Hypoglycemia
_ Hyperthyroid
_ Diabetes Type I
_ Diabetes Type II
_ Night Sweats
_ Unusual Sweating
_ Feeling Hot or Cold

Musculo-Skeletal:
_ Neck / Shoulder Pain
_ Muscle Spasms / Cramps
_ Arm Pain
_ Upper Back Pain
_ Mid Back Pain
_ Low Back Pain
_ Leg Pain
_ Osteoporosis
_ Arthritis
_ Joint Pain

Liver Conditions:
_ Hepatitis A
_ Hepatitis B
_ Hepatitis C

Head, Eye, Ear, Nose & Throat:
_ Impaired Vision
_ Eye Pain/Strain
_ Glaucoma
_ Glasses / Contacts
_ Tearing / Dryness
_ Impaired Hearing
_ Ear Ringing
_ Earaches
_ Ear Infections
_ Headaches
_ Sinus Problems
_ Nose Bleeds
_ Teeth Grinding
_ Frequent Sore Throats
_ TMJ / Jaw Problems
_ Hay Fever

Genito-Urinary Tract:
_ Kidney Disease
_ Kidney Stones
_ Painful Urination
_ Dribbling Urination
_ Frequent UTI
_ Frequent Urination
_ Blood in Urine
_ Discharge
_ Incontinence

Gastrointestinal:
_ Stomach Ulcers
_ Changes in Appetite
_ Nausea / Vomiting
_ Epigastric / Abdominal Pain
_ Passing Gas
_ Heartburn
_ Belching
_ Gall Bladder Disease
_ Gall Bladder Stones
_ Hemorrhoids
_ Indigestion
_ Constipation
_ Diarrhea
_ Irritable Bowel Syndrome
_ Leaky Gut Syndrome

Neurological:
_ Vertigo / Dizziness
_ Paralysis
_ Numbness / Tingling
_ Loss of Balance
_ Seizures / Epilepsy
_ Dyslexia
_ Insomnia
_ Poor Memory

Respiratory:
_ Pneumonia
_ Asthma
_ Frequent Common Colds
_ Difficulty Breathing
_ Emphysema
_ Persistent Cough
_ Pleurisy
_ Tuberculosis
_ Shortness of Breath

Other:
_ Cancer
_ Type:_____
_ Fibromyalgia
_ Lupus
_ Candida
_ Anemia
_ Rashes
_ Eczema / Hives
_ Hemophilia

Other (continued):
_ Significant Trauma
Type:_____
_ Significant Dental Work
_ Alcoholism
_ AIDs/HIV
_ Childhood illnesses
_ Chicken Pox
_ Measles
_ Mumps

Surgical History:

_____
_____
_____

Allergies or Pharmaceutical Reactions:

_____
_____
_____

MEDICAL HISTORY (CONTINUED)

Please check all that apply:

Family History:

_ Asthma _ Cancer _ Diabetes _ Heart Disease

_ Obesity _ Stroke _ Hypertension

Men Only:

_ Impotence _ Vasectomy Date: _____ _ Prostate problems

_ Testicular Pain / Redness / Swelling _ Seminal emissions

_ Low libido _ Excessive libido _ Painful Intercourse

Women Only

Are you pregnant right now? _ Yes _ No _ Trying _ Maybe

Method of Birth Control: _____

Age at first period: _____ Start Date of last menses: _____ Age at menopause: _____

Typical length of menses (days): _____ Typical length of cycle (from 1st day to 1st day of menses): _____

Number of: Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____

Hysterectomy: _Yes No Date: _____ Menopause: _Yes No

Check all that apply:

_ Low libido _ Excessive libido _ Painful Intercourse _ Clotting

_ Painful Periods _ Heavy Flow _ Scanty Flow _ Inter-Cycle Bleeding

_ Irregular Cycles _ Vaginal Discharge _ Breast Tenderness _ Nipple Discharge

_ Infertility _ Moodiness _ PMS _ Endometriosis

_ Fibroids _ Fibrocystic Breasts _ Ovarian Cysts _ Abnormal Pap Smear

PHARMACEUTICALS AND SUPPLEMENTS

Please list the medications and supplements you are currently taking:

Drug / Supplement Reason for taking for how long Dose Frequency

_____

_____

_____

_____

_____

I am taking Coumadin / Warfarin _ Yes _ No I am taking Plavix/ Aspirin _ Yes _ No

I have a pacemaker _ Yes _ No

LIFESTYLE

Are you… _ Vegetarian? _ Vegan?

Have you ever been on a restricted diet? _ Yes _ No

Do you consume alcohol? _ Yes _ No

How often do you drink alcohol? _____ How Much?: _____

Are you a smoker? _ Yes _ No

How long have you been a smoker? _____

How would you rate the following areas of your health in the past month:

Energy: _ Great _ Good _ Fair _ Poor Comments: _____

Sleep: _ Great _ Good _ Fair _ Poor Comments: _____

Diet: _ Great _ Good Fair Poor Types of Food: _____

Exercise: _ Great _ Good _ Fair _ Poor Comments: _____

Immunity: _ Great _ Good _ Fair _ Poor Comments: _____

How do you feel about the following areas of your life in the past month:

Significant Other: Great Good Fair Poor N/A Comments: _____

Family: Great Good Fair Poor N/A Comments: _____

Sex Life: Great Good Fair Poor N/A Comments: _____

Self: Great Good Fair Poor N/A Comments: _____

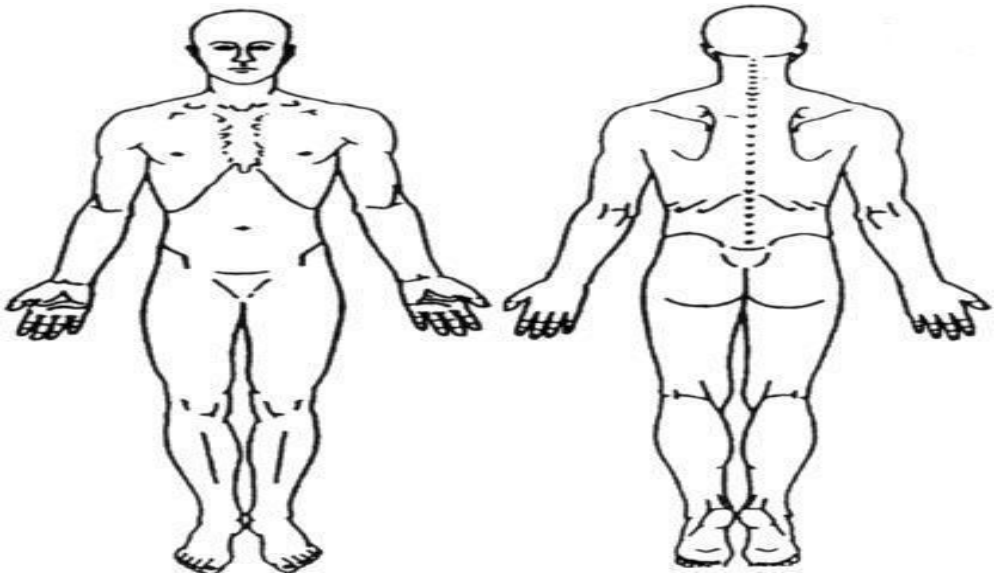
Work: Great Good Fair Poor N/A Comments: _____

How would you rate your current stress level? _ Extreme _ Very High _ High _ Moderate _ Low

PAIN

Please answer the following questions if you have pain.

Indicate on the diagram areas of pain:



Quality of pain: _ Dull _ Sharp _ Stabbing _ Sore _ Cramping _ Burning _ Constant _ Fixed _ Moves about

On a scale of 1 – 10 (10 being worst) how strong is your pain? _____

Does the pain radiate? _ Yes _ No Where? _____

What helps the pain? _ Ice _ Heat _ Rest _ Movement _ Pressure _ Moisture _ Massage _ Nothing

_ Other: _____

What aggravates the pain? _ Ice _ Heat _ Rest _ Movement _ Pressure _ Moisture _ Massage _ Nothing

_ Other: _____

Other treatments you have had for your pain?

_____

Cause of pain? _ Injury / Accident _ Disease _ Unknown

Comments? _____

_____

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Cornerstone Wellness Center 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

Patient Signature _____ **Date:** _____

Parent / Guardian (if applicable) _____

INFORMED CONSENT FOR TREATMENT

Patient Name: _____

By signing below, I hereby consent to be treated by Cornerstone Wellness Center Licensed Acupuncturist who approves all treatments and is available to address any questions or concerns.

I understand I may refuse or stop treatment at any time. I understand acupuncturists practicing in the State of Arizona are not primary care providers, and that regular care by a licensed physician is strongly recommended.

Initial _____Acupuncture: I understand that all acupuncture needles are single use, of the finest quality, and sterile. Application of low intensity electrical stimulation and/or heat may be used in conjunction with acupuncture. Certain adverse side effects could result, which include, but are not limited to: bruising, slight puffiness, dizziness, fainting, pain, discomfort, or exacerbation of pervious symptoms.

Initial _____Cupping/Gua Sha: I understand any devices that may come into contact with my skin, such as cupping (applying glass cups using heat to create suction) and gua sha (rubbing the skin with a specialized object), are disinfected prior to my session. I am aware these treatments are intended to cause minor bruising and are generally painless. Certain adverse side effects could result, which include, but are not limited to: bruising, soreness, achy muscles, or exacerbation of previous symptoms.

Initial _____Chinese Herbs: I understand specific nutritional/herbal supplements or lifestyle changes may be recommended in order to optimize my treatment goals, and are not required to continue receiving treatments. If I do agree to the recommendations, I will follow the specific dosage guidelines outlined in my prescription. Certain adverse side effects could result, which include, but are not limited to: abdominal/digestive discomfort or pain, nausea, vomiting, or exacerbation of previous symptoms. If I experience any adverse side effects, I will quit taking the herbs and call Cornerstone Wellness Center as soon as possible; or I will seek help from a licensed physician.

Initial _____Pregnancy: I will notify the Licensed Acupuncturist if I currently am pregnant or are trying to become pregnant, so that (s)he will avoid any acupuncture points or treatments that may adversely affect pregnancy or my attempts to become pregnant. However, I understand the practice of acupuncture and related treatments can be very beneficial for fertility, pregnancy, and/or birthing process.

Initial _____Dignity: I understand that treatments are designed to be therapeutic. To ensure this while receiving my treatments, I will let the student intern know if there are any procedures that feel uncomfortable or disagreeable in any way. During the treatment(s), I may experience emotional releases, such as crying or feelings of anger or elation. If that should occur, Cornerstone Wellness Center staff will continue to provide me with safe, caring, and private care to work through my experiences.

Initial _____Privacy: I understand that if it is necessary to disrobe during treatment, it will be to my level of comfort, and adequate and professional draping will be used. I give the Licensed Acupuncturist permission to treat any areas of my body in accordance with his/her recommendations.

Initial _____Cancellation Policy: I understand that if I need to cancel or reschedule my treatment, I will make every possible attempt to give Cornerstone Wellness Center at least 24 hours advance notice. I understand that if I arrive late for my appointment, my treatment may be cancelled or shortened in order to accommodate the Licensed Acupuncturist's next appointment.

- No Show: missing a scheduled appointment without notifying Cornerstone Wellness Center *
- Late Cancel: cancelling a scheduled appointment with less than 24 hours' notice*

(*subject to case by case review where appropriate)

After the first occurrence of a No Show or Late Cancel, I will receive a courtesy reminder of Cornerstone Wellness Center's Cancellation policy. Any subsequent No Shows or Late Cancels will result in a balance being placed on my account equal to the cost of the missed appointment. The balance must be paid in full prior to receiving any further treatments. Payments may not be made over the phone.

Patient Signature: _____ **Date:** _____

CORNERSTONE WELLNESS CENTER

Release / Consent Form for Acupuncture

NAME: _____

ADDRESS: _____

PHONE: _____ Email: _____

Please read the following and sign below:

Chinese Herbology and Acupuncture are natural methods of obtaining internal balance based on traditional Chinese / Oriental philosophy. As you work with Chinese herbs and / or Acupuncture, you may notice that you feel a difference as you attempt to balance your body. You may also notice that it may take a period of time to attain a state of balance. This is very natural.

If you are presently under the care of a physician and / or are currently taking medications, please consult your physician before making any changes in your current medical regime. Please be aware that the herbs may not work as efficiently, or might even produce unwanted side effects if taken in conjunction with other herbs or medications, or if taken improperly. Also, one may experience temporary skin discoloration or bruising from Acupuncture or Chinese massage. Very rare but potential risks include pneumothorax, and burns from moxabustion.

By signing this form, you hereby expressly release the Cornerstone Wellness Center, from any duty to refer you to a traditional medical practitioner. You also agree to receive herbs and / or acupuncture from a practitioner, and accept the risk of any side effects or consequences that arise as a result of the normal practice of Herbs, Acupuncture, and Oriental Medicine.

Always feel free to ask any questions you might have.

I HAVE READ AND FULLY UNDERSTAND THE STATEMENTS ABOVE. I UNDERSTAND THAT I AM TAKING HERBS AND ACUPUNCTURE TO IMPROVE MY OVERALL WELL-BEING. I CHOOSE TO PROCEED AND TAKE THESE HERBS AND / OR RECEIVE ACUPUNCTURE OF MY OWN VOLITION AND WITH INFORMED CONSENT I FURTHER UNDERSTAND THAT CORNERSTONE WELLNESS CENTER DOES NOT WARRANT, EITHER EXPRESSLY OR IMPLIEDLY, THE RESULTS, EFFECTS OR OUTCOME OF THE CHINESE HERBS. SHOULD ANY GRIEVANCE ARISE I HEREBY AGREE TO BINDING ARBITRATION AS A MEANS OF HANDLING AND DISPUTE.

_____

Patient Signature Date

Office Policy, Procedures & Disclosures

Medical/Chiropractic Department:

I understand that there is a $35 charge for missed appointments, without a 24 hour advanced notice, for any appointment with the Chiropractic Physician, Physical Therapist, Acupuncturist and or the Massage Therapist.

I understand that the patient is ultimately responsible for full payment for their treatment and care. Your insurance policy is a contract between you and your insurance. As a courtesy, we check your insurance or superbill. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for the payment of copays, co-insurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients are responsible for contacting their insurance carrier for explanation of any services not covered. Payment is due at the time of service, and for your convenience, we accept cash, and most major credit and debit cards at our office. Some insurance companies send you the provider's checks; you as the patient are responsible to bring those checks to our office with the EOB's as soon as you receive them.

Consent to care:

As a patient with Cornerstone Wellness Center, you have the right to know the types of treatment we could possibly use and any complications/side-effects to such treatment. The procedures performed in our clinic are usually beneficial, however unexpected issues may arise. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not provide specific treatments if he/she is aware that such care may be contraindicated. I am responsible for informing my doctors about any conditions, diseases, illness, etc. I agree to settle any claim or dispute against or with our clinic or personnel, when related to the prescribed care or otherwise, by binding arbitration under current malpractice terms which can be obtained by written request. Cornerstone Wellness Center may refer you out to other ancillary services that Cornerstone Wellness Center may have ownership to. I hereby allow treatment to be rendered to myself by all Cornerstone Wellness Center, Physicians or staff.

Financial Policy:

I agree that any insurance checks sent directly to me or insurance policy holder for services rendered with Cornerstone Wellness Center will be brought into our clinic.

I the undersigned, assign directly to **Cornerstone Physical Medicine LLC (dba Cornerstone Wellness Center)** all insurance benefits, if any, payable for services rendered to my minor child or myself. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of healthcare information and records to all insurance companies and to other treating providers whom I am seeking care from.

****

I have read, understand, and agree to the provisions of this Patient Financial Responsibility and Disclosure Form:
Please sign/date below:

Patient Name (print):_____ Date:_____/_____/_____

Patient Signature:_____

Health Care Information Authorization

At times our office may need to contact you with appointment information about treatment or other health related information. By signing below, you are giving **Cornerstone Wellness Center authorization** to contact you by the following:

(Please draw a single line through any methods you REFUSE and initial)

- I may be contacted by home, work, or cellphone.
- Messages may be left on my home, work, or cell voicemail OR to any individuals answering my phone at home or work.
- Also I may be contacted by postal mail or e-mail to send personalized cards (birthday/holiday/special events), office newsletter, special office announcements or appointment reminders. With my permission, my name and or photograph may be used for office events, bulletin boards, newsletters or patient testimonials.

You have the right to revoke this AUTHORIZATION, in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the privacy Official of **Cornerstone Wellness Center.** The written notice must contain the following information:

- Your name, social security number and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

The revocation is not effective until it is received by the Privacy Officials.

This AUTHORIZATION is requested by **Cornerstone Wellness Center** for its own use/disclosure of protected health information. (Minimum necessary standards apply.) You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION **Cornerstone Wellness Center** will not refuse to provide treatment. You have the right to inspect or copy the protected health information to be used/disclosed.

****** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST******

Personal representatives (family members, attorneys, etc.) I hereby authorize **Cornerstone Wellness Center** and its personnel to discuss, send and/or receive medical information to/with the following individuals:

_____ _____

Name Relationship to patient

_____ _____

Name Relationship to patient

We like to co-manage your case with your Primary Care Physician; do you authorize us to send notes or records to them? Yes No

If yes, please provide us the following information: Primary Care Doctor_____

Office Phone:(_____)-_____-_____

My signature below indicates that I have read and agree to the above authorization and I acknowledge that I have read a copy of **Cornerstone Wellness Center** Notice of Privacy Practices.

Patient Name (print):_____ Patient Representative (print):_____

Patient Signature:_____ Patient Representative Signature:_____

Date:_____/_____/_____

For Providers Use Only

1)Body Temp

2)Head, Eyes, ENT

3)Face

4)Chest/Abdomen

5)Neurological

6)Musculoskeletal

7)Appetite/Digest

8)Thirst

9)BM/Urine

10)Sleep

11)Energy/Emotion

12)Menstrual