Chiropractic Rehabilitation WELLNESS CENTER
115 Main Street, Vista, Ca. 92084 _ Phone: 760-726-9660 _ Fax: 760-726-8865

Welcome

We would like to welcome you to our Acupuncture and Oriental Medicine Department of the WELLNESS CENTER. We want to provide you with the most caring and efficient treatment. In order to do that, here are some guidelines:

_ **Appointments:** We strive to run "on time". Occasionally, however, an emergency will disrupt the schedule. We apologize in advance should that occur and delay your visit in any way. Your prompt arrival for scheduled appointments will help keep us running smoothly.

_ **Cancellations:** We understand that circumstances arise that may prevent your keeping an appointment. We request 24 hours notice of cancellation whenever possible so that we may give your time to someone else who may need it.

_ **Fees, payment policy, and insurance:** The fees charged in our office are comparable to those charged by other health care providers in this area. Health and accident policies are an arrangement between you and your insurance company. You will be personally responsible for payment of all services charged.

_ **For Patients with no insurance:** It is customary to pay for professional services when rendered unless other arrangements have been made. We ask that you pay with cash, check, or credit card. We accept Visa, MasterCard, Discover, American Express and Care Credit.

_ **For Patient's injured on the job "Worker's Compensation":** Your employer is responsible for any costs in treating your work-related injury, including attorney's fees, if necessary. <u>If Your Injury Is Work Related Be Sure And Tell Us Before Starting Treatments. It is necessary to get pre-authorization.</u>

_ **For Patients with Insurance:** This Office will gladly prepare insurance forms and reports. If Acupuncture benefits have not been verified or authorized, we may ask that you pay up front for services rendered. We will reimburse you after we receive payment form your insurance company. All professional services are the basic responsibility of the patient or responsible party.

_ **Herbal Formulas:** <u>All herbal and nutritional sales are final!</u>

_ **What we offer:** The healing tools we make available to you may include any or all of the following: Acupuncture, Chinese Herbal medicine, Tui-Na, Gua-Sha, Acupressure, Cupping, moxibustion, electrical stimulation and Clinical Nutrition.

_ **The Initial Visit:** We will discuss your concerns, take a very detailed history, and together with you devise a treatment plan. This process may take up to 1 hour. At the end of your visit, you may receive herbs or nutrients that may be appropriate.

We look forward to addressing your medical concerns in an empowering and creative way. Please feel free to give us comments on any aspect of our service, so that we may provide the best possible care.

Name _____

Date_____

ACUPUNCTURE
ORIENTAL MEDICINE
NEW PATIENT QUESTIONAIRE

Chiropractic Rehabilitation WELLNESS CENTER

NAME_____**Birthdate**_____ **Age**_____

Address_____**City**_____**State**_____**Zip**_____

Home Phone _____**Cell Phone** _____ **Work Phone**_____

Sex: M F Marital Status: M S D W Name of Spouse _____**#Children**____

Occupation_____**Employer**_____

Describe Duties:_____

What kind of Activities/Hobbies?_____

Referred By_____

REASON FOR VISIT TODAY: _____

Have you had Acupuncture or Chinese Herbal Medicine before? ☐ **YES** ☐ **NO**

How long have you had this condition? _____

Is it getting worse? _____ **Does it bother your:** ☐ **Sleep** ☐ **Work** ☐ **Other** _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Are you under the care of a physician now? ☐ **Yes** ☐ **No If yes, for what?**_____

Who is your Physician? _____ **Physician's Phone:** _____

Other concurrent therapies: _____

Do you have HEALTH INSURANCE? _____ **Name of Insurance:** _____

Insurance ID# _____ **Policy #** _____

Insurance Co. Address _____

Insurance Co. Phone Number _____

Is this a WORK INJURY? _____**Have you been in an AUTOMOBILE ACCIDENT?**_____

( ) Past Year ( ) Past 5 years ( ) Over 5 years Describe accident:_____

Other Personal Injuries or Accidents?_____**Please describe:**_____

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the 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 acupuncturists 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 this office or any other office or clinic, whether signatories to this form or not.

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

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. 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 acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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, mineral, and animal sources) that have been recommended are traditionally considered save in the practice of Chinese 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 immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist 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 office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

ASSIGNMENT AND RELEASE: I authorize payment of benefits be made directly to this healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an 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's Name _____

Patient's Signature _____ Date Signed _____

To be completed by the patient's representative if the patient is a minor or is physically or legally incapacitated:

Print Name of Patient: _____

Print Name of Patient Representative: _____

Signature of Patient Representative: _____

Relationship or Authority of Patient: _____

Name of Acupuncturist: Amy Rogers-Cavender, L. Ac. and/or Nima Arabani, D.C., L. Ac.

GENERAL HEALTH QUESTIONAIRE **NAME_____**

FAMILY MEDICAL HISTORY

_ Allergies
_____
_Cancer
_____
_Arteriosclerosis
_High Blood Pressure
_Stroke
_Diabetes
_Heart Disease
_Asthma
_Seizures
_Alcoholism

YOUR PAST MEDICAL HISTORY

_AIDS/HIV
_Alcoholism
_Allergies
_Appendicitis
_Arteriosclerosis
_Asthma
_Birth Trauma
_Cancer
_Chicken Pox
_Diabetes
_Emphysema
_Epilepsy
_Goiter
_Gout
_Heart Disease
_Hepatitis
_Herpes
_High Blood Pressure
_Multiple Sclerosis
_Measles
_Mumps
_Pacemaker
_Pleurisy
_Pneumonia
_Polio
_Rheumatic Fever
_Scarlet Fever
_Tuberculosis
_Seizures
_Stroke
_Thyroid Disorders
_Typhoid Fever
_Ulcers
_Venereal Disease
_Whooping Cough
_Surgery (list)
_____
_____
_Major Trauma
_____
_____
_Other
_____

YOUR DIET

Appetite _Low
_High
_Coffee
_Soft Drinks
_Artificial Sweetener
_Sugar
_Salty Food
Thirst for Water:
glasses/day_____

Pharmaceuticals taken in the last 2 months: _____

Vitamins/supplements taken in the last 2 months: _____

YOUR LIFESTYLE

_Regular Exercise
Type _____
_Marijuana
_Drugs
_Stress
_Occupational Hazards
_Alcohol
_Tobacco

GENERAL SYMPTOMS

_Poor appetite
_Heavy appetite
_Strongly like cold drinks
_Strongly like hot drinks
_Recent weight loss/gain
_Poor sleep
_Heavy sleep
_Dream-disturbed sleep
_Fatigue
_Lack of strength
_Bodily heaviness
_Cold hands or feet
_Poor circulation
_Shortness of breath
_Vertigo or dizziness
_Chills
_Fever
_Night sweats
_Sweat easily
_Muscle cramps

HEAD, EYES, EARS, NOSE, THROAT

_Glasses
_Eye strain
_Eye pain
_Red eyes
_Itchy eyes
_Spots in eyes
_Poor vision
_Blurred vision
_Night blindness
_Glaucoma
_Cataracts
_Teeth problems
_Grinding teeth
_TMJ
_Facial pain
_Gum problems
_Sores on lips or tongue
_Dry mouth
_Excessive saliva
_Sinus problems
_Excessive phlegm
Color of phlegm
_____
_Recurrent sore throat
_Swollen glands
_Lumps in throat
_Enlarged thyroid
_Nose bleeds
_Ringing in ears
_Poor hearing
_Earaches
_Headaches
_Migraines
_Concussions
Other head or neck problems
_____
_____
_____

RESPIRATORY

_Difficulty breathing when lying down
_Shortness of breath
_Pneumonia
_Tight chest
_Asthma/wheezing
_Cough
Wet or Dry?_____
Thick or thin? _____
Color of phlegm
_____
_Coughing blood

GENERAL HEALTH QUESTIONAIRE (page 2) **NAME**_____

CARDIOVASCULAR

_High blood pressure _Low blood pressure _Chest pain _Tachycardia _Heart palpitation
_Phlebitis _Blood clots _Irregular heartbeat _Difficulty breathing _Fainting

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GASTROINTESTINAL

_Nausea _Diarrhea _Bad breath
_Vomiting _Constipation _Itchy anus
_Acid regurgitation _Laxative Use _Burning anus
_Gas _Black stools _Rectal pain
_Hiccup _Bloody Stools _Hemorrhoid
_Bloating _Mucous in stools _Anal fissures
_Intestinal pain or cramping

Bowel Movements:
Frequency _____
Texture/form_____
Color_____
Odor_____

MUSCULOSKELETAL

_Neck/shoulder pain _Upper back pain _Joint Pain _Limited range of motion Other
_Muscle Pain _Low back pain _Rib pain _Limited use _____

SKIN AND HAIR

_Rashes _Eczema _Dandruff _Change in hair/skin texture _Other
_Hives _Psoriasis _Itching _Fungal infections _____
_Ulcerations _Acne _Hair loss _____

NEUROPSYCHOLOGICAL

_Seizures _Poor memory _Irritability _Considered/attempted suicide
_Numbness _Depression _Easily stressed _Seeing a therapist
_Tics _Anxiety _Abuse survivor _Other _____

GENITO-URINARY

_Pain on urination _Blood in urine _Venereal Disease _Increased libido _Impotence
_Frequent urination _Unable to hold urine _Bedwetting _Decreased libido _Premature ejaculation
_Urgent urination _Incomplete urination _Wake to urinate _Kidney Stone _Nocturnal emission

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GYNECOLOGY

_Age menses began _____ _Duration of flow _____ _Vaginal discharge (color)_____ _Breast lumps Date of last PAP
#pregnancies _____ _____
_Length of cycle _____ _Irregular periods _Painful periods _PMS _Vaginal sores _Vaginal Odor _Clots #live births_____ Premature births_____ Age at Menopause ____ Date last period began _____

OTHER

_____

_____

SIGNATURE _____ **DATE** _____