Heritage
ACUPUNCTURE & WELLNESS

Would you like to receive a copy of our newsletter containing helpful information about natural medicine and exclusive discounts?
Y N

Patient Information

Name: _____ Social Security Number: _____
(first) (middle) (last)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell: _____ Email: _____

Date of Birth: _____/_____/_____ Age: _____ Marital status: S M D W Occupation: _____

Employer: _____ Work Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Emergency Contact: _____Phone Number: _____ Relationship: _____

Successful health care and preventative medicine are most effective when the practitioner has a complete understanding of the patient. Please complete this questionnaire as thoroughly as possible. Thank you.

Please list your current health concerns: _____
_____
_____
_____
_____

List all other present and past diagnoses: _____
_____
_____

Indicate dates and types of surgeries and injuries: _____
_____
_____

List allergies or sensitivities (past and present): _____
_____
_____
_____

List any medications (prescribed and over-the-counter), vitamins and supplements you are currently taking:
_____ _____
_____ _____
_____ _____
_____ _____

Does Heritage Acupuncture have your permission to communicate with your primary and/or referring physician(s)? **Y N**
If so, please list the physician's name(s) and contact number(s). _____
_____
_____

Family History of (please circle):

Heart disease	Food Allergies	Arthritis	Hypothyroidism
Hypertension	Infectious diseases	Asthma	Hyperthyroidism
Hypercholesterolemia	Seizures	Anemia	Adrenal disorders
Hypotension	Cancer	Kidney disease	Diabetes
Stroke	Infertility	Depression	Alcoholism
IBS	Premature menopause	Emotional problems	Autoimmune diseases

Other disorders not listed above: _____
_____

Have you had any of the above illnesses? Please list. _____
_____

Have you been diagnosed with: Hepatitis B **Y N** Hepatitis C **Y N** HIV **Y N**

Current Height: _____ Weight: _____

Blood Pressure: What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

Lifestyle

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Please describe:

A typical breakfast: _____

A typical lunch: _____

A typical dinner: _____

Daily snacks: _____

Beverages: _____

Exercise routine: _____

c. How many hours per night of sleep: _____

Please indicate use and frequency of the following:

Tobacco _____ Coffee _____

Alcohol _____ Carbonated drinks _____

Sweets and desserts _____ Water _____

Recreational substances _____

Five Element Questionnaire

Please mark if you experience any of the below on a frequent basis (3-5x/week or more):

Wood	Fire	Earth	Metal	Water
__ Irritability				
__ Anger	__Palpitations	__ Body feels heavy	__Cough	__Urinary pressure or pain
__ Depression	__Dizziness	__Fatigue	__Nasal discharge	__Frequent urination
__ Headaches	__Insomnia	__Swelling	__Sinus pressure	__Incontinence
__ Migraines	__Easily startled	__Muscle aches	__Nose bleeds	__Knee pain
__ Visual issues	__Anxiety	__ Craving sweets	__Dry mouth	__Aching bones
__ Red eyes	__Breathlessness	__Excessive hunger	__Skin rashes	__Feeling cold easily
__Dry eyes	__Vivid dreams	__Low appetite	__Dry skin	__Low sexual energy
__Chest tightness	__Difficulty concentrating	__Frequent worrying	__Oily skin	__Excess sexual desire
__Lump in throat	__Lack of joy	__Hypoglycemia	__Itchy skin	__Fear
__Jaw clenching		__Nausea	__Shortness of breath	__Poor memory
__Muscle cramps		__Gas	__Allergies	__Hearing problems
__Stiff joints		__Bloating after meals	__Frequent colds	__Ringing in ears
__Acid reflux		__Loose stool	__Low physical stamina	__Night sweats
__Belching		__Hemorrhoids	__Asthma	
__PMS				

For Women:

Age at onset of menses: _____ First day of last period: _____ Are you pregnant? Y N

Number of: A) Children born _____ B) Miscarriages _____ C) C-sections _____ D) Abortions _____

Painful periods? Y N Irregular periods? Y N

For Men:

Decrease in urinary flow/pressure:	Y	N
Premature ejaculation:	Y	N
Infertility:	Y	N
Nocturnal emission:	Y	N
Low libido:	Y	N

Cash Payment Policy Information

Payment at time of service is required unless you have purchased a series of treatments, available with Facial Rejuvenation services. A $35 charge applies to all returned checks. Herbal and/or nutritional supplements may be invoiced separately from treatments; payment is requested before delivery of such herbs and/or supplements.

I plan to settle my bill today by paying by cash, MasterCard, Visa, Discover or personal check: ____ Initial

Cancellation Policy

Heritage Acupuncture & Wellness LLC kindly requests 24-hours notice to cancel or reschedule an appointment. Patients who are 20 minutes late or more are considered a no-show. I understand that I may be charged a cancellation fee of 50% of the scheduled service for missed appointments or appointments cancelled or rescheduled without 24 hours notice. If I pay for Heritage services with insurance benefits I understand the cancellation fee must be paid out of pocket: ____ Initial

Insurance Information

Company: _____ ID Number: _____ Group Number: _____

Secondary Insurance Company: _____ ID Number: _____ Group Number: _____

Insurance Payment Policy Information

I understand that all deductibles, copayments and products or services not covered by my insurance plan are my responsibility. Clients with insurance benefits must pay co-payments, if required, at the time of service. Insurance benefits must be verified before undergoing treatment. I understand that it is my responsibility to inform the provider if my insurance plan or provider changes. Should collections be necessary, the patient shall pay Heritage Acupuncture on demand all costs, including reasonable attorney's fees incurred in collecting payment due for services performed under this agreement. I understand that although insurance benefits may cover certain visits, I am responsible for no show fees should I fail to cancel or reschedule at least 24 hours before an appointment.

Assignment

I permit payment directly to Heritage Acupuncture & Wellness LLC for any benefits due for services rendered and products provided. I understand that I am financially responsible for all charges, whether or not covered by my insurance company. ____ Initial

Medical Records

Authorization is hereby granted for release of any information required to process my insurance claim. A copy of this authorization is as valid as the original. Regardless of any claim pending you will receive periodic statements if your account has an outstanding balance. Heritage cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Informed Consent and Disclosure

I hereby request and consent to acupuncture, acupuncture-related modalities, herbal recommendations, skin care services and/or other forms of treatment for myself (or my legal charge) provided by Janet Lee, L.Ac., of Heritage Acupuncture LLC, hereby known as the Acupuncturist. I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure and the treatment plan which the Acupuncturist determines in my best interest.

I understand that Acupuncture is one part of Oriental Medicine, which also may include the procedures listed below. I agree to the Acupuncturist's use of these treatments if indicated.

Acupuncture is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the affected area. It also is normal for the patient to have a temporary warm sensation or feeling of pressure at the acupuncture site. Dizziness or temporary fatigue are possible outcomes. I understand that some patients feel a temporary increase in symptoms before they feel relief. Hematoma or bruising also is a possible result of acupuncture treatment. Rare outcomes include skin rash or tingling. Extremely rare possibilities include pneumothorax or other organ puncture.

Acupressure/TuiNa involves rubbing, kneading, pressing and other massage manipulations which may result in muscle soreness at the massage site that can last for several days. This technique and others described here may involve disrobing. I understand that all attempts will be made to assure my privacy.

Indirect moxibustion requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burn exists.

Cupping involves a localized suction produced by creating an oxygen vacuum in a small glass cup. A normal outcome is temporary marks called "sha" which resemble bruises. Slight burning or blistering are also possibilities.

Gua sha involves scraping over a cutaneous area with a smooth instrument. This technique also may result in temporary "sha" marks.

Tapping, plum blossom, bleeding and pricking all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site are a likely occurrence. Only single-use needles are used in these procedures.

Electrical stimulation/TENS uses microcurrent electricity to stimulate acupuncture points. During this technique it is normal to feel a mild tingling sensation.

Treatment using points Ren 1 and Du 1 may be applied in rare cases. This involves using acupuncture points in the perineum area. If this treatment is necessary, the Acupuncturist will notify me and will provide alternative treatments if I am uncomfortable. I understand all attempts will be made to assure my privacy.

Chinese herbalism involves the use of a number of plant and mineral derived medicinals commonly used in Chinese medicine. I understand that the Acupuncturist is trained and licensed for the use of these materials. The use of Chinese herbalism will be determined by the Acupuncturist's expertise. Chinese herbal treatment may occasionally result in digestive upset. I understand that following the Acupuncturist's dosage and usage recommendations for herbal and other supplements is an important part of the treatment outcome.

I understand that Acupuncture and Chinese Medicine are commonly prescribed in a course of treatment, which may include herbalism, dietary recommendations, lab testing and analysis, exercises or other lifestyle changes. I acknowledge that my compliance to these recommendations will affect the treatment plan. I recognize that one treatment is not a course of treatment.

I understand that the Acupuncturist cannot guarantee results and cannot anticipate all possible risks involved in treatment.

I have read or have had read to me the above consent and understand the risks involved. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindictions and/or suboptimal results. I am aware that it is my responsibility to inform the provider of my current medical or health conditions and to update this history. I understand that the information herein is to aid the provider in giving better service and is completely confidential. The services I receive here are voluntary, and I release Heritage Acupuncture & Wellness LLC and this provider from any liability resulting from this or any services received at Heritage or from any products or tools used during treatments or purchased from Heritage Acupuncture LLC and assume full responsibility thereof.

Authorization for Release of Medical Information: I further understand that the Acupuncturist may need to contact my medical physician when it is determined that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to: the diagnosis of diseases or request for lab and/or radiology results, withdrawal from prescription drugs, severe depression or other conditions. This coordination of care intends to manage my health condition in my best interest and to assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to the Acupuncturist to contact my medical physician if/when necessary.

Treatment of Pediatric Patients <3 Years. I understand that the treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to the Acupuncturist to contact my child's medical doctor if/when necessary.

_____

Patient Name (please print)

_____ _____

Signature Date