SCHEDULE

Chestnut Hill Family Acupuncture is currently accepting new clients. Jan welcomes you with a full heart. Please fill out the following forms and bring them with you to your first appointment.

PREPARING FOR TREATMENT

It is a good idea to have something in your belly before receiving an acupuncture treatment. You do not want to be too full or too hungry before treatment. It's best to wear loose fitting, comfortable clothing. Other than that, come as you are. Your acupuncture sessions may quickly become the most relaxing and rejuvenating part of your week.

CANCELLATION POLICY

Jan values her time in the treatment room with you and strives to give you her full attention during your appointment. In order for the daily schedule to go smoothly, it is important for you to arrive for your appointment on time. If you find that you are running late, please let Jan know by phone or text. She will try and accommodate you when you arrive.

If you have an emergency which will keep you from making your appointment please call the office to reschedule 24 hours in advance. Failure to call ahead will result in the full treatment payment fee.

PAYMENT

Payment is due at the time of service. Jan accepts personal checks. If your insurance company covers acupuncture Jan will furnish you with a receipt for your treatment which you can send into your insurance company for reimbursement.

Chestnut Hill Family Acupuncture
7825 Germantown Avenue
Philadelphia, PA 19118
267-670-0989
jan@chillacu.com
chillacu.com

CONFIDENTIAL HEALTH HISTORY

Welcome! Please take the time to fill out this questionnaire fully. Your answers are strictly confidential.

Today's Date _____

Name _____ Date/Place of Birth _____

Address _____ City _____ State _____ Zip _____

Phone: Work _____ Home _____ Cell _____

Email _____ Age _____ Height _____ Weight _____ Sex _____

Occupation _____ Referred by _____

Name & Phone of Physician _____

Emergency Contact Name & Phone _____ Relationship _____

Below, please briefly describe what would you like treated with acupuncture, when this condition(s) developed, how it has affected you, any medical diagnoses, and what kind of therapies you have already tried.

_____

_____

_____

_____

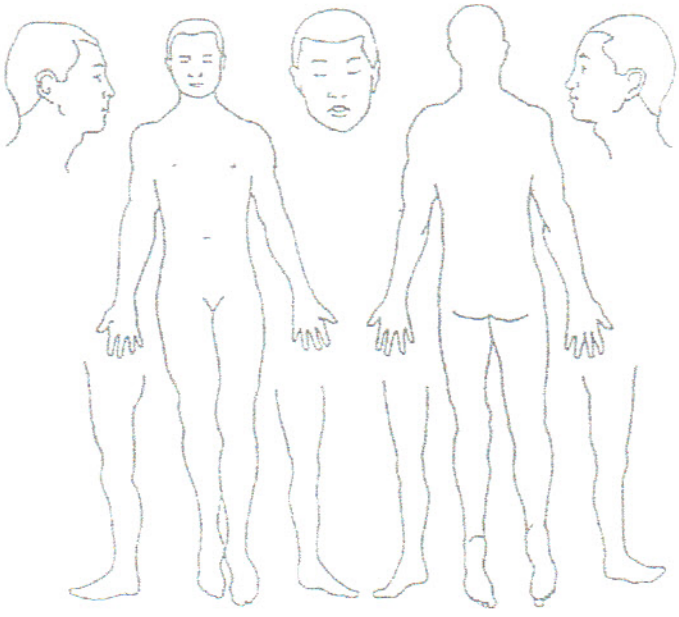
_____

_____

_____

Are you currently pregnant? _____ **Are you presently trying to become pregnant?** _____

Please shade any areas of pain or distress on the diagram below:



Rate your degree of physical distress (0=none, 10=worst possible): 0 1 2 3 4 5 6 7 8 9 10

Rate your degree of emotional distress (0=none, 10=worst possible): 0 1 2 3 4 5 6 7 8 9 10

Medical History

Please check off any current or former conditions and include dates as well as any relevant information.

- ☐ AIDS/HIV _____ any neuropathies? _____
- ☐ Alcoholism _____
- ☐ Allergies _____
- ☐ Asthma _____ difficulty inhaling ☐ difficulty exhaling ☐
- ☐ Autoimmune disease _____
- ☐ Birth complications _____
- ☐ Cancer _____
- ☐ Diabetes _____ any neuropathies? _____
- ☐ Emphysema _____
- ☐ Hepatitis A/B/C *(please specify)* _____
- ☐ Heart Disease _____
- ☐ Lyme disease _____
- ☐ Lymph Nodes removed - where? _____ can you have injections on that side? _____
- ☐ Multiple Sclerosis _____
- ☐ Pacemaker _____
- ☐ Rheumatic or Scarlet Fever _____
- ☐ Seizures _____
- ☐ Tuberculosis _____
- ☐ Thyroid disease _____
- ☐ Vaccine reactions _____

Please list any serious trauma, broken bones, head injuries, scarring wounds, onset of health changes, recurring, chronic or major illnesses, other relevant events, and ALL surgeries:

Age _____ _____
Age _____ _____
Age _____ _____
Age _____ _____
Age _____ _____
Age _____ _____
Age _____ _____
Age _____ _____
Age _____ _____
Age _____ _____
Age _____ _____

Scars from injury/surgery: _____

_____

Family Medical History Please list major illnesses in your close family such as diabetes, cancer, heart disease, autoimmune, neurological, psychological, orthopedic etc.

_____

_____

_____

Medications: List all medications (including over-the counter) and herbs you are taking, and why. _____

_____

_____

_____

_____

_____

Exercise: What you do and how often? _____

_____ Do you fatigue easily? _____

Diet: Typical breakfast _____ Are you vegan? _____

Lunch _____ Lacto / ovo vegetarian? _____

Dinner _____ How long? _____

Snacks _____

Food cravings? _____ Food intolerances? _____

How much and how often do you have the following:

Sugar / Sweets _____ Water _____

Artificial sweeteners _____ Alcoholic beverages _____

Coffee _____ Cigarettes _____ per day

Soda _____ for _____ years

Date quit: _____

How often do you move your bowels? _____

Any problems with bowels? _____

Urination problems or changes? *(e.g. frequent, painful, unusual color)* _____

Emotions: How do you feel emotionally? _____

_____

_____

Major sources of stress: _____

How / where do you hold stress? _____

How do you relax? _____

How is your sleep? _____

Women: Current/past use of birth control pill or other hormone therapies _____

_____

IU device, tubal ligation or other similar birth control _____

Age at first menses ____ Days between cycles _____ Duration of flow Date of last menses _____

Usual color/quality of blood _____ Recent changes? _____

Symptoms related to menstrual cycle: _____

Number of pregnancies _____ deliveries _____ abortions _____ miscarriages _____

Pregnancy and delivery notes *(C-Section, health issues, other complications)* _____

_____

Age at menopause _____ Menopause symptoms _____

_____

Please **(Circle)** any problem you have now and **Underline** items that were severe or chronic in the past

Misc: anemia - fatigue/exhaustion - hypoglycemia - motion sickness – tremors/ticks - poor balance - fever - chills - other _____

Skin, Hair, Nails: dry skin - rashes - itching - acne - eczema - hives - ulcerations - fungal infections - psoriasis dry hair - dandruff - hair loss - brittle nails - other _____

Cardiovascular: Have you been diagnosed with any heart trouble? _____
pacemaker - fast pulse >100 bpm - slow pulse <60 bpm - chest pressure or pain - shortness of breath palpitations/arrhythmia - high blood pressure - low blood pressure - flushed face - dizziness/vertigo fainting - phlebitis - varicose veins - cold hands and feet - cold sweats - poor circulation - blood clots bruise easily - other heart or blood vessel problems _____

Gastro-intestinal: poor appetite - always hungry – can't control eating - difficult or painful bowel movement - abdominal pain - distention/bloating - ulcer - nausea - vomiting - vomiting with blood - acid reflux - lack of stomach acid - foul breath - belching - intestinal gas - irritable bowel - diarrhea/loose stool - constipation - hard stool - blood in stool - black stool - hemorrhoids - chronic laxative use - other_____

Respiratory, Eye/Ear/Nose/Throat, Head: chronic cough - coughing blood - asthma/wheezing bronchitis - pneumonia - tuberculosis - shortness of breath on exertion/at rest - difficulty breathing lying down - excessive phlegm - frequent colds - nose bleeds - chronic runny nose - chronic stuffy nose - post-nasal drip sinus problems - painful/red eyes - poor vision - see spots - night blindness - blurry vision ear pain/infections - poor hearing - ringing in ears - sore throat - streptococci infections - bleeding gums sores on lips or tongue - gum problems - dental abscess - facial pain - TMJ /jaw pain - other _____ frequent headaches/migraines (describe) _____

Urinary: frequent urination - painful urination - burning urination - blood in urine - trouble starting stream urgency to urinate - incontinence - urinary tract infections - kidney stones - pale urine - dark yellow urine Do you wake at night to urinate? _____ other _____

Musculoskeletal: arthritis/joint pain - tendonitis - rheumatism - repetitive strain - muscle pain where? _____ pain is: sharp - burning - dull/aching - deep - superficial - tingling better with heat - better with cold - better with rest - better with movement or massage - worse in a.m. or p.m.

Women: irregular menstruation - pain before / during / after menses - heavy / light / no bleeding - clots - spotting between periods - vaginal itching/burning or pain - PMS symptoms - yeast infection - breast lumps - breast tenderness - discharge from breasts - infertility - menopausal symptoms - reduced sexual energy genital sores - genital pain - other _____

Men: prostatitis - impotence - premature ejaculation - seminal emission - reduced sexual energy - genital sores genital pain - penis blood/mucus discharge - vasectomy - other _____

Is there anything else you wish to bring to our attention:

_____ Thank you!

Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture by Jan Wilson, licensed acupuncturist. I understand that acupuncturists practicing in the state of Pennsylvania are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, nerve damage, organ puncture, including lung puncture (pneumothorax), spontaneous miscarriage, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Cupping: I understand that if I receive cupping as part of my treatment, that bruising is a common side effect of treatment. I understand that I may refuse this therapy.

Use of Heat Lamp: I understand that burning is a possible risk if treatment includes the use of a heat lamp. I understand that I may refuse this therapy.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. 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. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

SIGN BELOW *ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

*X*_____ *X*_____

Patient's Signature Date Explained by me and signed in my presence Date

Parent/Guardian (if applicable)_____

HIPPA, The Health Insurance Portability and Accountability Act of 1996, established rights and protections for healthcare consumers and created responsibilities for healthcare providers.

The HIPPA Privacy Rule of April 14, 2001 requires healthcare providers to implement administrative, technical, and physical safeguards to ensure the security of your individually identifiable health information.

The following is informing you of the implementation of these Privacy Policies by Jan Wilson, L.Ac and Chestnut Hill Family Acupuncture. Your signature at the bottom of this document acknowledges that you have been made aware of your rights. You are entitled to a copy of this notice.

On your initial visit, I will ask you to sign an **Acupuncture Consent Form and a Health History Inventory.** Each time you visit the clinic for your acupuncture treatment, a written record of your session is made on my **Acupuncture Progress Notes.** This contains results of your Verbal and Physical Assessment, Acupuncture Diagnosis, Acupuncture Treatment (including acupuncture points or adjunct tools used), and Recommendations or Referrals.

Therefore, any data collected from your physician in compliance with this regulation will be placed on your chart. A request for your acupuncture records will be sent to your physician's office only with your written permission. All of your written acupuncture records and any medical records sent from your physician will be kept confidential.

I, _____ have read, reviewed, understand, and agree to the statement of Private Policy for health care received by Jan Wilson, L.Ac.

Signature_____Date_____

Parent/Guardian (if applicable) _____