ENERGY LIFE SCIENCES INSTITUTE

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INTEGRATIVE HEALTH CARE

Welcome to the Energy Life Sciences Clinic. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential! If you have questions, please ask.

PATIENT CONFIDENTIAL INFORMATION

Name: _____ Email: _____

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

Sex: ☐ M ☐ F DOB: _____ Age: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced

Cell Phone: _____ Home Phone: _____

Employer: _____ Work Address: _____

Main problem you would like us to help you with: _____

_____

How long ago did this problem begin? Please be specific: _____

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

_____

_____

Emergency contact - Name: _____ Phone: _____

Primary Care Physician - Name: _____ Phone: _____

Address: _____

Patient Signature: _____ Date: _____

Referred by: _____

THIS INFORMATION WILL BE USED ONLY FOR PURPOSES OF RECORD KEEPING AND BILLING

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MEDICAL INSURANCE

At the Clinic, our policy and our belief is that we have a relationship with you, the patient, and you have a relationship with your medical insurance. Services are paid at the end of each session unless other arrangements have been made.

There is a wide range of coverage for acupuncture in today's insurance plans and we are happy to find out what coverage your particular plan has. If your coverage allows, we will contract our insurance biller to submit and follow up on your claims, which will in this case be billed by procedural codes. Please note that you might only have a partial coverage, or you may have a fixed co-pay as part of your plan. If your insurance provider has paid their portion of your services and there is still an outstanding balance owed: you will be responsible for payment of the balance. Please note that if your insurance company sends payment directly to you instead of to the clinic, you are responsible to endorse the check to the clinic or write a new check for the full amount.

If you will submit to your insurance, we will happily provide you with a statement that includes all the codes that your carrier will want to see in order to process your reimbursement. Just add your plan ID number and your social security next to your name before sending in the form.

Please note that you are responsible for notifying us of any changes in your plan that might affect your coverage, and you are responsible for payment of any portion of your services that are not covered due to those changes.

24-HOUR CANCELLATION POLICY

If you need to cancel your scheduled appointment, please notify us as soon as possible. Due to the limited number of appointment time slots, giving us 24 hours notice allows us to fill your cancellation from the waiting list. If you cancel an appointment with less than 24 hours notice you will be charged the fee for the visit.

I have read the above statement and I fully understand the cancellation policy as described above, and authorize Energy Life Sciences Institute to charge my credit card the full fee for the missed appointment. Your CC information is part of your account set up for any services you want to enjoy when it is convenient for you to use your card on file.

Your information will be kept confidential and will not be used without your prior authorization.

Patient Name – Please Print _____ Date _____

Credit Card Number _____ Expiration Date _____ 3-digit Code _____ Billing Zip Code _____

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INFORMED CONSENT TO ACUPUNCTURE AND CHINESE HERBAL TREATMENT

I consent to acupuncture and herbal treatments and other procedures associated with Chinese medicine 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 the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatments may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal medicine, and nutritional counseling.

Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain, and of treating certain diseases and imbalances of the body. Most people experience a sense of wellbeing and relaxation during and after the treatment. I have been informed that acupuncture is a safe method of treatment, but that occasionally bruising, numbness or tingling at the site of needle insertion may occur after treatment. Bruising is also a possible side effect of cupping. Rare side effects include dizziness or fainting, especially if the patient is overdue for a meal. Burns on the skin are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects may occur. Unusual risks of acupuncture include nerve damage and lung puncture (pneumothorax).

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe 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 notify a clinical staff member who is caring for me if I am pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts that then known is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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.

Patient Name _____ Date _____

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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

The following policies have been adopted:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.

2. It is the policy of Energy Life Sciences Institute to remind patients of their appointments. This may be done by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to policy.

3. You agree to bring any concerns or complaints regarding privacy to the attention of the practitioner.

4. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

5. We agree to provide patients with access to their records in accordance with state and federal laws.

6. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

7. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used by Energy Life Sciences Institute concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date: _____

hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM

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HEALTH QUESTIONNAIRE

Name: _____ Date: _____

PAST MEDICAL HISTORY *(Select all that apply)*

☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ High Blood Pressure

☐ Heart Disease ☐ Thyroid Disease ☐ Seizure ☐ Asthma

Other *(list)* _____

Allergies *(list all – chemical, foods, drugs)*: _____

Surgeries: _____

Significant Trauma *(auto accidents, falls, etc.)*: _____

How many hours a night do you sleep on average?

Do you have trouble falling asleep? ☐ Yes ☐ No Waking up in the night? ☐ Yes ☐ No

Are there areas of your life that are stressful? *(Select all that apply)*:

☐ Home ☐ Work ☐ Family ☐ Psychological Stress ☐ Physical Stress

Do you exercise regularly? ☐ Yes ☐ No If yes, what type and frequency? _____

_____

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes/cigars per day? _____

Medicines taken within the last two months *(vitamins, drugs, herbs, etc)*:

MEDICA TIONS	DOSAGE	REASON

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NUTRITION

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other ☐ Yes ☐ No

If yes, what type of diet? _____

Describe your average daily diet. Morning: _____

Afternoon: _____

Evening: _____

How many cups of caffeinated coffee, tea, or cola do you drink per week? _____

How many times per week do you drink alcohol? _____

How many 8 oz. glasses of water do you drink per day? _____

How many hours a night do you sleep on average? _____ Do you have trouble falling asleep? ☐ Yes ☐ No

CARDIOVASULAR

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Fainting

☐ Irregular heart beat ☐ Difficulty breathing ☐ Blood clots ☐ Phlebitis

☐ Cold hands/feet ☐ Swelling of hands ☐ Swelling of feet ☐ Palpitation

☐ Palpitations at rest ☐ Varicose or spider veins

Any other heart or blood vessel problems? _____

RESPIRATORY

☐ Cough ☐ Coughing blood ☐ Asthma ☐ Bronchitis

☐ Pneumonia ☐ Chest tightness ☐ Pain with deep breath ☐ Loss of Hair

☐ Difficulty breathing lying down ☐ Phlegm production. Color?

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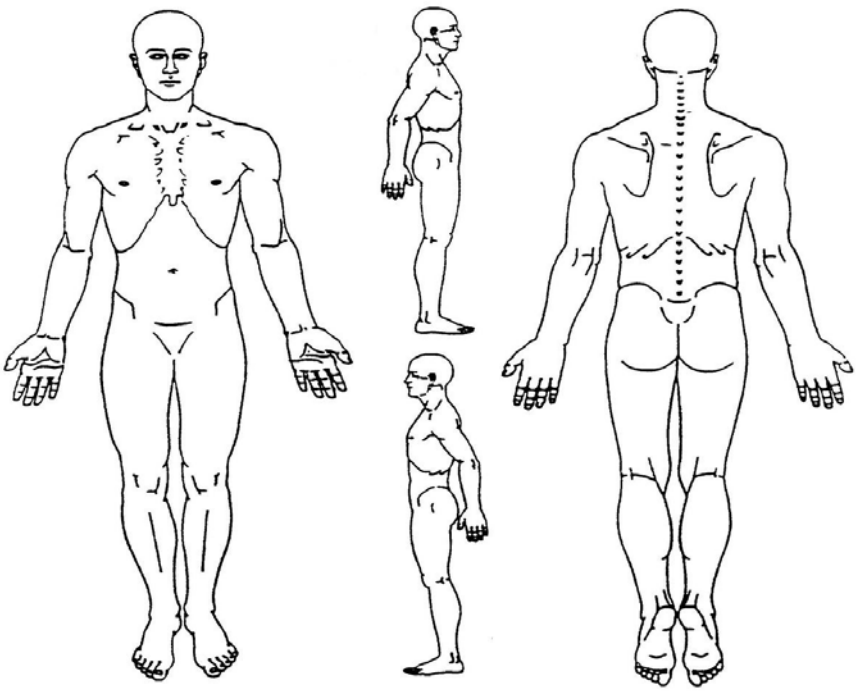
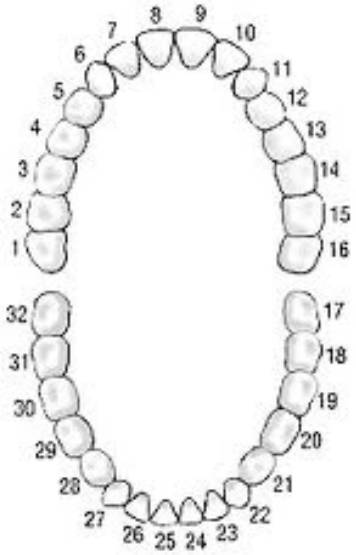
DENTAL HEALTH

Do you have any mercury fillings? ☐ Yes ☐ No If yes, how old are they? _____

Do you have any root canals? ☐ Yes ☐ No If yes, please mark the teeth in the chart.

Please indicate all painful or distressed body areas by circling the specific area:





PAIN/DISCOMFORT SCALE

Please circle on the scale of 1 to 10 below the level of pain or discomfort associated with your main complaint:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Least pain *Severe pain*

If your main complaint does not include pain or discomfort, please indicate the severity of your complaint:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Not a problem *Very severe*

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Please list 3 most significant stressful events in your life. Are any of these situations continuing to impact you today?

1. _____

2. _____

3. _____

GENERAL *(Please check if you have had any of the following in the last 3 months)*

☐ Fevers ☐ Night sweats ☐ Weight loss ☐ Cravings

☐ Chills ☐ Fatigue ☐ Poor sleep ☐ Bruise Easy

☐ Weight gain ☐ Change in appetite ☐ Peculiar tastes or smells

Sudden energy drop. What time of day? _____

☐ Strong thirst for ☐ Hot drinks ☐ Cold drinks

REPRODUCTIVE & GYNECOLOGIC

Are you pregnant? ☐ Yes ☐ No Is it possible that you are pregnant? ☐ Yes ☐ No

Number of pregnancies: _____ Live births: _____ Miscarriages: _____

Age at first menses: _____ Premature births: _____ Abortions: _____

Duration of menses *(number of days flowing)*: _____ Last PAP: _____

How many days long is your menstrual cycle: _____

☐ Irregular periods ☐ Painful periods ☐ Endometriosis ☐ Breast lumps

☐ Vaginal sores ☐ Vaginal discharge ☐ Clots ☐ Fibrocystic breast

☐ Uterine fibroids ☐ Polycystic Ovary Disease ☐ Vaginal dryness

Color of blood: ☐ Dark red ☐ Bright red ☐ Pale red ☐ Brown

Any unusual characteristic of the blood? *(Heavy, scanty, etc.)*

Do you practice birth control? ☐ Yes ☐ No If yes, what type? _____ How long? _____

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HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Spots in front of eyes
- ☐ Poor hearing
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Recurrent sore throats
- ☐ Grinding teeth
- ☐ Clenching jaw
- ☐ Facial pain
- ☐ Sores on lips and tongue
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Headaches, where and when? _____
- ☐ Any other head or neck problems? _____

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of Hair
- ☐ Recent moles
- ☐ Psoriasis
- ☐ Dermatitis
- ☐ Acne
- ☐ Change in hair or skin texture
- ☐ Any other skin or hair problems?

GATROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Black stool
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Rectal pain
- ☐ Blood in stool
- ☐ Indigestion
- ☐ Bad breath
- ☐ Bloating/edema
- ☐ Hemorrhoids
- ☐ Bleeding gums
- ☐ Hernia
- ☐ Poor appetite
- ☐ Diarrhea
- ☐ Colitis
- ☐ Excessive appetite
- ☐ Abdominal pain/cramps
- ☐ IBS/Crohn's
- ☐ Loose stools
- ☐ Slow digestion
- ☐ Acid reflux/GERD
- ☐ Laxative use

Any other problem with stomach or intestines? _____

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GENITO-URINARY

☐ Frequent urination ☐ Blood in urine ☐ Painful urination ☐ Impotency

☐ Urgency to urinate ☐ Unable to hold urine ☐ Kidney stones ☐ Decrease flow

☐ Wake at night to urinate. How many times per night? _____ ☐ Sores

What color is the urine? ☐ Yellow ☐ Pale Yellow ☐ Cloudy Red tinged ☐ Dark Yellow

Any other problems with your genital or urinary systems?_____

MUSCULOSKELETAL

☐ Neck pain ☐ Tendonitis ☐ Foot/ankle pain ☐ Knee pain

☐ Muscle pain ☐ Muscle weakness ☐ Shoulder pain ☐ Hip pain

☐ Sciatica ☐ Sprains/strains ☐ Hand/wrist pain ☐ Carpel tunnel

☐ Back pain ☐ Low ☐ Middle ☐ Upper

NEUROLOGICAL & EMOTIONAL

☐ Seizures ☐ Dizziness ☐ Loss of balance ☐ Concussion

☐ Poor memory ☐ Areas of numbness ☐ Poor coordination ☐ Easily angered

☐ Numbness/Tingling Where?_____ ☐ Anxiety ☐ Depression

☐ Nervousness ☐ Easily susceptible to stress ☐ Manic depression

☐ ADD/AHD ☐ Have you ever been treated for emotional problems? ☐ Yes ☐ No

Any other neurological or emotional problems?

Do you practice any form of meditation? ☐ Yes ☐ No What kind and how often? _____

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THANK YOU