Whole Body Acupuncture & Wellness Center

Confidential Health Information Form

BASIC INFORMATION

Name:_____ DOB:____/____/____ Email:_____

Phone: (cell/home/work):_____ Can I leave a message?:_____

Address:_____ City:_____ State:_____ ZIP:_____

PO Box/Mailing Address:_____ Occupation:_____

Current medical doctor or other healthcare provider:_____

Have you ever received Acupuncture or taken Chinese herbs: Y / N

If so, purpose and date of last visit: _____

How did you hear about Whole Body Acupuncture?:_____

CONDITIONS/ISSUES

What are the top three issues you are seeking help with & how long have you been dealing with the issue:

1)_____ How long:_____

2)_____ How long:_____

3)_____ How long:_____

What is your main goal with treatment?:_____

BODY SYSTEM REVIEW

What is your current average **energy level** from 1-10 (1 being bedridden, 10 being very high): _____

What is your current **stress** level: mild moderate high extremely high

How many hours do you **sleep** on average: _____ Time to bed: _____ Time to wake: _____

What is a typical day of **eating and drinking** for you?

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

Anything you *do not* eat?:_____

Do you **exercise**: Y / N How many times per week?:_____

Type(s):_____

Are your **stools** usually: formed constipated loose/diarrhea alternating

Do you regularly experience any pain in your body, including headaches. Please explain:

Please answer the following questions:

Abdominal, rib side, or breast distention and pain	Never	1-2 Month	1-2 Week	Daily
Easily irritated, angered, or frustrated	Never	1-2 Month	1-2 Week	Daily
See floaters (spots) in your eyes	Never	1-2 Month	1-2 Week	Daily
High stress level	Yes	No		
Feel better with exercise or movement	Yes	No		
Dry eyes or brittle nails	Yes	No		
Fatigue after eating	Never	1-2 Month	1-2 Week	Daily
Abdominal bloating or gas	Never	1-2 Month	1-2 Week	Daily
Digestive issues	Never	1-2 Month	1-2 Week	Daily
Loose stools	Never	1-2 Month	1-2 Week	Daily
Cold hands and feet	Never	1-2 Month	1-2 Week	Daily
Feeling of heaviness or lack of strength in extremities	Never	1-2 Month	1-2 Week	Daily
Bruise easily	Yes	No		
Prone to excessive worry	Yes	No		
Excessive thirst or dry mouth	Never	1-2 Month	1-2 Week	Daily
Night sweats or hot flashes	Never	1-2 Month	1-2 Week	Daily
Insomnia or trouble sleeping	Never	1-2 Month	1-2 Week	Daily
Heart palpitations	Never	1-2 Month	1-2 Week	Daily
High blood pressure	Yes	No		
Anxiety or panic attacks	Yes	No		
Easily excitable/restless or excessively withdrawn	Yes	No		
Stuffy or runny nose	Never	1-2 Month	1-2 Week	Daily
Breathing issues - including asthma or allergies	Never	1-2 Month	1-2 Week	Daily
Skin issues – rashes, eczema, psoriasis, etc.	Yes	No		
Get sick often or easily	Yes	No		
Extreme fatigue or lack of motivation	Never	1-2 Month	1-2 Week	Daily
Low pitch ringing in the ears	Never	1-2 Month	1-2 Week	Daily
Decrease libido	Never	1-2 Month	1-2 Week	Daily
Chronic low back or knee pain	Yes	No		
Often fearful	Yes	No		
Infertility or premature aging	Yes	No		

MEDICATIONS - Please list all prescriptions, OTC medicines, vitamins, and natural supplements you take:

ALLERGIES - Please list any allergies or sensitivities to any medications, foods, or environmental elements:

OPERATIONS/HOSPITALIZATIONS - Please list any hospitalizations or operations, including dates:

MEDICAL HISTORY - Please list any abnormal lab/test results (PAP, blood pressure, cholesterol, diabetes, thyroid, etc.):

Please **circle** any conditions you currently have or have had:

AIDS/HIV Alcoholism Allergies Anxiety Asthma Autoimmune Illness type:_____

Cancer type:_____ Diabetes Depression Heart disease Hepatitis type:_____

High Blood Pressure High Cholesterol Stroke Tuberculosis Thyroid Disorder type:_____ Pacemaker: Y /N

Please list any relevant family history of illness or disease:

FEMALES

Date of last menses (first day of bleeding):_____ Is your cycle regular?:_____

Average number of days between cycles:_____ Average number of days bleeding:_____

How is your flow: light moderate heavy clotted watery dark red bright red

Do you experience cramps?: Y / N If so, are they before, during, or after bleeding?:_____

Number of pregnancies:_____ Full-term:_____ Miscarriages:_____

What kind, if any, of birth control are you on:_____

Age of menopause onset:_____

Circle if you experienced any of the following: hot flashes night sweats mood swings

Did or do you use hormone replacement therapy: Y / N if so, what kind:_____

COMMENTS - Please let us know if there is anything else we should know about:

Disclosure and Informed Consent Form

Whole Body Acupuncture & Wellness Center
Julie Predki-Weber, Dipl.OM, L.Ac
1206 Mulligan Vista Morenci, AZ 85540
(312) 914-2278

Practitioner

Julie Predki-Weber, MSOM, Dipl. OM, received her Masters of Oriental Medicine at Southwest Acupuncture College, in Boulder, CO, graduating in August of 2013. Her schooling including over 3,400 hours of instruction, including over 1,000 clinical hours, in which Julie studied acupuncture, herbs, and a number of adjunctive therapies within the scope of Traditional Chinese Medicine, including but not limited to: moxa, cupping, guasha, and tuina. She is board certified in acupuncture and herbs through the NCCAOM, the National Certification Commission for Acupuncture and Oriental Medicine.

Fees

Fee for treatment will be taken at the time of service, first time treatments cost $50 and follow-up treatments are $40. Insurance is not accepted, but a super bill will be provided upon request that you can submit for possible out of network reimbursement from your insurance provider.

Informed Consent

I hereby request and consent to the performance of acupuncture procedures and any other modality covered under the scope of acupuncture practice by Julie Predki-Weber. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including, but not limited to: discomfort, pain, bruising, or numbness at or near the site of needling, and dizziness or fainting. Unusual and rare risks of acupuncture include: nerve damage, organ puncture (including lung puncture), and spontaneous miscarriage. Infection is possible, but unlikely because only sterile, single use needles are used. Other side effects and risks may occur. If I suspect that I am pregnant, I will IMMEDIATELY inform the acupuncturist. I will also inform Julie of any other health conditions, including but not limited to: infectious disease, high blood pressure, or use of blood thinners like Coumadin.

I have discussed the nature and purpose of my treatment with Julie Predki-Weber. I understand that there are no guarantees regarding care or improvement of my condition. I understand there may be limitations to the care provided and that in my best interest I may be referred to another acupuncturist or other healthcare practitioner who may be more qualified to treat me outside of these facilities. You are entitled to receive information about methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and may terminate therapy at any time. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts known. I understand that I have the choice to accept or reject treatment at any time. All records are kept confidential and will not be released without my written consent.

I have read or have had read to me the above consent and have had the opportunity to ask questions. By voluntarily signing below, I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

_____	_____	_____
Signature of Patient/Person authorized to consent	Printed name	Date