

**Whole Family Wellness Center**  
**New Patient Information**

**Patient Information:**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Street Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Office Phone \_\_\_\_\_  
Mobile Phone (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Domestic partnership \_\_\_\_ Other  
\_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Office/cell phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Date of last visit \_\_\_\_\_

Employment (please check all that apply):  
full-time \_\_\_\_ part-time \_\_\_\_ self-employed \_\_\_\_ student \_\_\_\_ unemployed \_\_\_\_ retired \_\_\_\_

Occupation \_\_\_\_\_ Number of hours of work/study per week \_\_\_\_\_

Employer's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Billing and Insurance**

Primary Insurance \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Primary Insurance Address \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Policy # / ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder's Birth date \_\_\_\_\_

**Missed Appointment Policy**

If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in being charged the full price of your visit.

\_\_\_\_\_ I understand cancellation policy.

**Confidentiality**

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

## Health History

Have you had acupuncture treatment before? If so, for what reason? \_\_\_\_\_

What was the outcome? \_\_\_\_\_

### Digestion

past current

- nausea / vomiting
- belching
- heartburn
- bad breath
- bleeding gums
- ulcers
- excessive appetite
- change in appetite
- nose bleeds

past current

- gas
- abdominal bloating
- abdominal pain
- decreased appetite
- indigestion
- low energy / fatigue
- crave sweets
- decreased sense of taste/smell
- difficulty swallowing

past current

- diarrhea
- constipation
- blood in stools/black
- pus in stools
- hemorrhoids
- anal fissures
- rectal pain
- gallstones
- crave sour foods

### Respiratory/Skin/Head

past current

- frequent colds
- sinus infection
- production of phlegm
- hay fever or allergies
- dry eyes
- red eyes
- itchy eyes
- aversion to wind
- chills

past current

- pneumonia
- bronchitis
- itching
- dry skin
- acne
- eczema or psoriasis
- ear infections
- night sweats
- enlarged lymph

past current

- laryngitis/hoarse voice
- crave pungent foods
- COPD
- asthma
- recurring sore throat
- cough
- cough with blood
- fevers
- sweat easily

### Urinary / Reproductive

past current

- frequent urination
- urgency to urinate
- pain on urination
- urine incontinence
- weak urine stream
- blood in urine
- kidney stones
- low back pain
- sore / weak knees
- crave salty foods
- frequent or strong thirst
- decreased libido
- genital lesions
- genital discharge

*(Females only)*

past current

- frequent urinary tract infections
- frequent vaginal infections
- pelvic inflammatory disease
- abnormal PAP smear
- irregular periods
- premenstrual syndrome
- painful menstrual periods
- abnormal bleeding
- menopause symptoms
- breast lumps

*(Males only)*

past current

- impotence
- premature ejaculation
- testicular lumps
- prostatitis
- genital itching/pain

### **Females only:**

Total Pregnancies \_\_\_\_\_

    living \_\_\_\_\_ Ectopic \_\_\_\_\_ Miscarriages \_\_\_\_\_ Induced Abortion \_\_\_\_\_

Age of first menses: \_\_\_\_\_

Age of menopause: \_\_\_\_\_

Type of birth control you currently use: \_\_\_\_\_

**Circulation/Heart Meridian**

past current

- \_\_ high blood pressure
- \_\_ low blood pressure
- \_\_ palpitations
- \_\_ irregular heart beat
- \_\_ tend to feel warm

past current

- \_\_ chest pain or pressure
- \_\_ jaw, neck, shoulder or arm pain
- \_\_ poor memory
- \_\_ swollen hands or feet / edema
- \_\_ tend to feel colder than others

past current

- \_\_ blood clotting disorders
- \_\_ phlebitis
- \_\_ crave bitter foods
- \_\_ cold hands / feet

**Nervous System / Emotions**

past current

- \_\_ insomnia
- \_\_ excessive /vivid dreams
- \_\_ grinding teeth
- \_\_ blurred vision
- \_\_ poor night vision
- \_\_ glasses/contact lenses
- \_\_ visual changes
- \_\_ cataracts
- \_\_ ear ringing – high pitch
- \_\_ ear ringing – low pitch
- \_\_ floaters (spots in the visual field)

past current

- \_\_ migraines / headaches
- \_\_ dizziness
- \_\_ fainting
- \_\_ seizures
- \_\_ localized weakness
- \_\_ numbness or tingling of limbs
- \_\_ tremors
- \_\_ paralysis
- \_\_ tendonitis
- \_\_ concussion
- \_\_ cold sweats

past current

- \_\_ depression
- \_\_ anxiety / stress
- \_\_ irritability
- \_\_ poor concentration
- \_\_ indecisiveness
- \_\_ often feel angry
- \_\_ often feel worried
- \_\_ often feel scared
- \_\_ treated for emotional / psychological problems

**Infectious Illness** Please mark any **positive** test results you have had:

past current

- \_\_ HIV
- \_\_ TB
- \_\_ chicken pox
- \_\_ meningitis

past current

- \_\_ gonorrhea
- \_\_ chlamydia
- \_\_ syphilis
- \_\_ hepatitis

past current

- \_\_ SARS
- \_\_ west nile
- \_\_ genital warts
- \_\_ herpes oral / genital

Other past or current infectious diseases \_\_\_\_\_

**Recent tests** (please indicate results)

Cholesterol \_\_\_\_\_ Blood pressure \_\_\_\_\_ Mammography \_\_\_\_\_  
 Prostate \_\_\_\_\_ Blood work \_\_\_\_\_

Other tests and results \_\_\_\_\_

Please list any tumors or lumps you currently have or have had in the past:

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**Pain-** please describe any pain you have (L = left, R = right, B = both sides)

past current

- \_\_ head
- \_\_ jaw
- \_\_ neck
- \_\_ throat
- \_\_ shoulder L R B
- \_\_ upper arm L R B
- \_\_ elbow L R B

past current

- \_\_ forearm L R B
- \_\_ wrist L R B
- \_\_ hand L R B
- \_\_ fingers L R B
- \_\_ chest
- \_\_ rib / flank
- \_\_ abdomen

past current

- \_\_ upper back
- \_\_ mid-back
- \_\_ low back
- \_\_ hip L R B
- \_\_ thigh L R B
- \_\_ knee L R B
- \_\_ calf L R B

past current

- \_\_ shin l r b
- \_\_ ankle l r b
- \_\_ foot l r b
- \_\_ heel l r b
- \_\_ toes l r b

**Family History** (Complete for each family member, placing an X in the appropriate box):

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Asthma							
Hypo OR Hyperthyroidism							
Diabetes							
Irritable Bowel Syndrome							
Ulcerative Colitis							
Celiac Disease							
Depression							
Stroke							
High Blood Pressure							
Blood Disorder / Anemia							
Cancer or Tumors							
Seizures							
Kidney or Bladder Disease							
Stomach or Intestinal Disorder							
Drug / Alcohol Abuse							
Tuberculosis							
Heart Disease							
Age at Death							

**Major Hospitalizations/Surgeries/Accidents** – Please list any hospitalization, surgeries, or injuries you have had:

Year	Operation/Illness/Injury	Name of Hospital	City and State

**Medicines, Herbs, Supplements** (Please check any that you are currently taking)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Aspirin                 | <input type="checkbox"/> antacids          | <input type="checkbox"/> blood thinners | <input type="checkbox"/> sleeping pills  |
| <input type="checkbox"/> ibuprofen pills         | <input type="checkbox"/> fiber / laxatives | <input type="checkbox"/> blood pressure | <input type="checkbox"/> anti-anxiety    |
| <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> diet pills        | <input type="checkbox"/> insulin        | <input type="checkbox"/> antidepressants |
| <input type="checkbox"/> allergy medication      |  |   |  |

Please list any of the following currently being taken:

Western Drugs	Herbs	Vitamins and Supplements

Drug Allergies: \_\_\_\_\_

How many times in the last year have you taken Antibiotics? \_\_\_\_\_

In the last 5 years? \_\_\_\_\_

Did you supplement with probiotics (acidophilus)? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you traveled to developing countries? If yes, please describe:

Where did you travel? \_\_\_\_\_ How long ago? \_\_\_\_\_ How much time did you spend there? \_\_\_\_\_

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**Habits** (Please check any habits which apply to you now or in the past)

Substance	Yes?	No?	How often? (please indicate daily or weekly intake)	Age started	Age quit
Coffee					
Tobacco					
Marijuana					
Wine / Beer					
Liquor					
Crack / Cocaine					
Heroin					

**Diet**

Please describe any restricted diet you follow(ed) now or in the past:

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Please describe your typical daily diet:

Breakfast \_\_\_\_\_ Morning Snack \_\_\_\_\_

Lunch \_\_\_\_\_ Afternoon Snack \_\_\_\_\_

Dinner \_\_\_\_\_ Evening Snack \_\_\_\_\_

Known Food Allergies \_\_\_\_\_

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Known Food Sensitivities \_\_\_\_\_

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Please list your health concerns in order of importance:

Please describe any regular program of exercise:

Do you have a religious or spiritual practice? If so, please describe:

What are the top priorities in your life?

What are your expectations and/or hopes for the outcome of this treatment?

Please provide any additional information about yourself or your condition not covered by the above questions (please use the back of this paper).

## **Whole Family Wellness Center Informed Consent to Treatment**

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by at the Whole Family Wellness Center.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine, Homeopathy, Flower Essence Therapy, nutritional supplements and nutritional counseling.

I have had the opportunity to discuss with the practitioner at Whole Family Wellness Center the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. Following an acupuncture treatment, there may be dizziness or fainting. Although the practitioner maintains a clean environment and uses disposable needles, in rare cases infection of the needling site may occur. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping. Burns and scarring are potential side effects of moxibustion.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience gastro-intestinal upset, allergic reactions or any other undesirable effect to the herbs, I will inform the above named practitioner.

I will notify Whole Family Wellness Center I am or anticipate becoming pregnant.

I do not expect the practitioners at Whole Family Wellness Center to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise judgment during the course of the procedure which they feel at the time, based upon the facts then known, is in my best interest.

I understand that clinical 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, unless required to do so by law.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

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*To be completed by patient:*

PATIENT'S NAME \_\_\_\_\_  
(please print)

PATIENT'S SIGNATURE \_\_\_\_\_

DATE SIGNED \_\_\_\_\_

ARE YOU PREGNANT?    \_\_\_ YES \_\_\_ NO

*To be completed by the patient's representative, if necessary, e.g., if patient is a minor or is physically or legally incapacitated:*

NAME OF PATIENT \_\_\_\_\_  
(please print)

PATIENT'S REPRESENTATIVE \_\_\_\_\_  
(please print)

REPRESENTATIVE'S SIGNATURE \_\_\_\_\_

AS: \_\_\_\_\_  
Relationship or Authority of Patient's Representative

DATE SIGNED \_\_\_\_\_

# **WHOLE FAMILY WELLNESS CENTER**

## **FINANCIAL POLICIES**

1. All fees for services are due at the time of visit unless previous arrangements have been made.
2. Most conditions require an average of 4-12 treatments, although some will respond well in fewer visits and others may require a longer series – this depends on the severity and the chronic nature of the chief complaint.
3. Your appointment time is reserved specifically for you. In the event of a missed appointment, an appointment cancelled with less than 24 hours notice, or arriving later than 20 minutes after your appointment time, please note you will be charged the full price of your visit.
4. There is a service charge of \$25 for every returned check.
5. Fees for services are as follows. Please note that payments made at the time of service will receive the “payment at the time of service discount” and all other payments will be charged the full fee.

	Full Fee	Payment at the time of service Discount
<u>Adults:</u>		
New patient consultation, exam & treatment	\$190	\$150
Follow up consultation & treatment	\$130	\$85
<u>Children:</u>		
New patient consultation, exam & treatment	\$190	\$150
Follow up consultation, exam & treatment- 30 min.	\$110	\$75
Follow up, treatment only- 15 min.	\$55	\$38

6. Herbal Supplements for adults, approximately \$8-\$25/week

\*\*\*\*Please note: Sliding scale is available for all patients showing financial need. Please speak to me before our first appointment if you require consideration for a lower fee.

Please indicate your understanding and acceptance of these policies by signing below.

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Signature

Date

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Printed Name

# **Whole Family Wellness Center Privacy Policies**

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. *This notice will remain in effect until it is replaced or amended by changes in law.*

**We gather personal information and health information in several ways:**

- Information we receive from you;
- Information we receive from other healthcare providers; and
- Information we receive from third party payers.

\*This information is used for treatment, payment and healthcare operations.

\*You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

\*You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

**Marketing**

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, or mail.

**Disclosure**

This office may use or disclose your Protected Health Information when required by law.

**Patient Rights**

1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of \$10-20 and with 10 working days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information, please contact this office.

**I have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office.**

**If I would like to review the Privacy Policies I may request a copy at the front desk of Whole Family Wellness Center, 1240 Powell St, Ste 2-A, Emeryville, CA 94608.**

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**WHOLE FAMILY WELLNESS CENTER**  
**Authorization for Release of Medical Records**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_

I, \_\_\_\_\_, authorize the practitioners of Whole Family Wellness Center to release my medical records to the following practitioner(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

The release of my medical records can include but is not limited to health history, lab results, progress notes, & treatment plan.

With my signature below I hereby authorize the release of my medical records:

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_