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: Yelp [ ] Facebook [ ] Twitter [ ] Ad [ ] _____ (specify publication)
Referred By (Friend, Dr., Midwife, Doula) [ ] _____
BPN [ ] Holistic Parenting Support Group [ ] Other [ ] _____

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		past	current		past	current	
__	__	nausea / vomiting	__	__	gas	__	__	diarrhea
__	__	belching	__	__	abdominal bloating	__	__	constipation
__	__	heartburn	__	__	abdominal pain	__	__	blood in stools/black
__	__	bad breath	__	__	decreased appetite	__	__	pus in stools
__	__	bleeding gums	__	__	indigestion	__	__	hemorrhoids
__	__	ulcers	__	__	low energy / fatigue	__	__	anal fissures
__	__	excessive appetite	__	__	crave sweets	__	__	rectal pain
__	__	change in appetite	__	__	decreased sense of taste/smell	__	__	gallstones
__	__	nose bleeds	__	__	difficulty swallowing	__	__	crave sour foods

Respiratory/Skin/Head

past	current		past	current		past	current	
__	__	frequent colds	__	__	pneumonia	__	__	laryngitis/hoarse voice
__	__	sinus infection	__	__	bronchitis	__	__	crave pungent foods
__	__	production of phlegm	__	__	itching	__	__	COPD
__	__	hay fever or allergies	__	__	dry skin	__	__	asthma
__	__	dry eyes	__	__	acne	__	__	recurring sore throat
__	__	red eyes	__	__	eczema or psoriasis	__	__	cough
__	__	itchy eyes	__	__	ear infections	__	__	cough with blood
__	__	aversion to wind	__	__	night sweats	__	__	fevers
__	__	chills	__	__	enlarged lymph	__	__	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: _____

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Circulation/Heart Meridian

past	current		past	current		past	current	
__	__	high blood pressure	__	__	chest pain or pressure	__	__	blood clotting disorders
__	__	low blood pressure	__	__	jaw, neck, shoulder or arm pain	__	__	phlebitis
__	__	palpitations	__	__	poor memory	__	__	crave bitter foods
__	__	irregular heart beat	__	__	swollen hands or feet / edema	__	__	cold hands / feet
__	__	tend to feel warm	__	__	tend to feel colder than others			

Nervous System / Emotions

past	current		past	current		past	current	
__	__	insomnia	__	__	migraines / headaches	__	__	depression
__	__	excessive /vivid dreams	__	__	dizziness	__	__	anxiety / stress
__	__	grinding teeth	__	__	fainting	__	__	irritability
__	__	blurred vision	__	__	seizures	__	__	poor concentration
__	__	poor night vision	__	__	localized weakness	__	__	indecisiveness
__	__	glasses/contact lenses	__	__	numbness or tingling of limbs	__	__	often feel angry
__	__	visual changes	__	__	tremors	__	__	often feel worried
__	__	cataracts	__	__	paralysis	__	__	often feel scared
__	__	ear ringing – high pitch	__	__	tendonitis	__	__	treated for emotional / psychological problems
__	__	ear ringing – low pitch	__	__	concussion			
__	__	floaters (spots in the visual field)	__	__	cold sweats			

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

past	current		past	current		past	current	
__	__	HIV	__	__	gonorrhea	__	__	SARS
__	__	TB	__	__	chlamydia	__	__	west nile
__	__	chicken pox	__	__	syphilis	__	__	genital warts
__	__	meningitis	__	__	hepatitis	__	__	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:

_____

_____

_____

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

past	current		past	current		past	current		past	current	
__	__	head	__	__	forearm L R B	__	__	upper back	__	__	shin l r b
__	__	jaw	__	__	wrist L R B	__	__	mid-back	__	__	ankle l r b
__	__	neck	__	__	hand L R B	__	__	low back	__	__	foot l r b
__	__	throat	__	__	fingers L R B	__	__	hip L R B	__	__	heel l r b
__	__	shoulder L R B	__	__	chest	__	__	thigh L R B	__	__	toes l r b
__	__	upper arm L R B	__	__	rib / flank	__	__	knee L R B			
__	__	elbow L R B	__	__	abdomen	__	__	calf 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)

____Aspirin
____ Ibuprofen pills
____ Acetaminophen (Tylenol)
____ allergy medication
____ antacids
____ fiber / laxatives
____ diet pills
____ blood thinners
____ blood pressure
____ insulin
____ sleeping pills
____ anti-anxiety
____ antidepressants

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?

_____
_____
_____

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					
Marijauna					
Wine / Beer					
Liquor					
Crack / Cocaine					
Heroin					

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

_____
_____
_____

Please describe your typical daily diet:
Breakfast _____ Morning Snack _____

Lunch _____ Afternoon Snack _____

Dinner _____ Evening Snack _____

Known Food Allergies _____
_____

Known Food Sensitivities _____

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 the acupuncturist at the Whole Family Wellness Center Clinic Medical Staff named below and/ or other acupuncturist(s) of the Clinic Medical Staff. I have discussed the nature and purpose of my treatment with the member of the Clinic Medical Staff named below.

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 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 Clinic Medical Staff members maintain a clean environment and use 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 Clinic Medical Staff.

I will notify the Clinic Medical Staff if I am, anticipate becoming, or become pregnant.

I do not expect the Clinic Medical Staff at the Whole Family Wellness Center to be able to anticipate and explain all risks and complications, and I wish to rely on the Clinic Medical Staff 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.

Discontinuation of services:
You may discontinue treatment at any time. Although it would be unusual for me to refuse services, I may do so at any time. Reasons for refusal of services include but are not limited to: abusive or disrespectful behavior; unpaid fees; repeated cancellation, non-attendance, or tardiness for appointments; intoxication. In addition, should I determine that the severity of your condition warrants higher levels of care, I may refer you to such care instead of or in addition to psychotherapy with me.

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.

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_____

To be completed by Clinic Medical Staff Member:

NAME_____ SIGNATURE_____ DATE SIGNED_____
(please print)

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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	$405	$250
Acupuncture treatment with Cupping	$315	$165
Acupuncture treatment without Cupping	$235	$125
<u>Children</u>:		
New patient consultation, exam & treatment	$405	$250
Follow up consultation, exam & treatment- 30 min.	$215	$120
Follow up, treatment only- 15 min.	$107.50	$60
<u>Telehealth</u>:		
For adults and children: 30 minutes		Payment at the time of service: $120

6. Herbal Supplements for adults, approximately $15-$40/week

****Please note: A Monthly Payment Plan is available for all patients showing financial need. Please speak to us before your first appointment if you require consideration for a lower fee.

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

_____

Signature Date

_____

Printed Name

Whole Family Wellness Center
Cancellation Policy Agreement

Whole Family Wellness Center has a strict 24 hour cancellation policy. Your appointment time is reserved specifically for you or your child, and we regularly turn away other patients for those times. Therefore, to protect our business and our time, we charge the ***FULL COST*** of your visit in the following circumstances:

- An appointment is cancelled with less than 24 hours notice
- Missing a scheduled appointment time, or
- A very late arrival to your appointment, where we are unable to see you without impacting our other patients.

We will make every effort to waive the cancellation fee in the following circumstances:

- We are able to fill your time slot with another patient
- We are able to reschedule you for a time on the same day that you missed an appointment
- We have an empty enough schedule in the following 1-2 business days after your missed appointment, that we can comfortably offer you an alternative, without effecting other patients' options for scheduling. Please note this is rare. Our schedule is often booked several weeks in advance. There must be enough available appointment times in the schedule that we feel comfortable we are not turning away other patients for that time, to be able to waive your cancellation fee. To have your fee waived, this option will only be offered directly through our office, and CANNOT be scheduled online. If you miss this alternate appointment for ***ANY*** reason, you will be charged the cancellation fee for your original missed appointment.

Please note the following:

- If we are billing your insurance for your acupuncture visits, please know your insurance ***DOES NOT*** cover missed appointments. You will be charge our *Payment at the time of Service* discounted rate, for your missed visit. These rates are as follows: $125 for adult follow up visits, $120 for 30 minute pediatric follow up visits, and $60 for 15 minute pediatric follow up visits. Please know we will ***NOT*** attempt to bill your insurance for missed visits.

- Please note a signed copy of this agreement will be emailed to you for your records.

Please indicate your acceptance of our Cancellation Policy by signing below.

_____

Signature Date

_____

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 I 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 _____