

Confidential Information Sheet

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____ City: _____ State _____

Zip: _____ Home Phone: _____ Work: _____ Cell: _____

Email: _____ Date of Birth: _____

Height: _____ Weight: _____ Age: _____ Sex: Male Female

Emergency Contact: _____ Emergency Phone Number: _____

Primary care doctor: _____ Last seen: _____

Your Occupation: _____ Employer: _____

Marital Status: Single Married Domestic Partner Divorced Widowed Separated

Number of Children: _____ Age of Children: _____ Number who live with you: _____

Others living with you: _____

How did you hear about us?

Google search Facebook LivingSocial Groupon Yelp

A talk Walk-in Networking event Other website/event: _____

Physician Referral (Name): _____ Ph # _____

Attorney Referral (Name): _____ Ph # _____

Patient Referral (Name): _____ Ph # _____

Insurance coverage for acupuncture? Yes No Unsure

Cancellation & Returns Agreement

CANCELLATION & RESCHEDULING POLICY

You may cancel or reschedule an appointment with no charge any time before the close of business on the business day preceding your appointment.

Same day cancellations, missed appointments, or same day rescheduling of an appointment to a different day will incur a charge of 50% of the scheduled service's regular price. (Essential: \$37.50 or Advanced: \$75)

An active credit card must remain on file with Healing House in order to reserve an appointment. This card will only be charged in the event that you cancel, miss, or reschedule an appointment on the same day.

If you are a member at Healing House and you do not have a pre-paid treatment credit, we will charge you 50% of the scheduled service's regular price for your missed or rescheduled appointment.

RETURNS POLICY

You may return any product bought at Healing House within 30 days of purchase to receive a full refund. The purchase receipt is required for a full refund. If you do not have a receipt, we can refund the credit or debit card that was used for purchase if you present that card and a valid ID. If you paid by credit or debit card, refunds will be issued directly to that card; however, if you paid by cash or check we will send you a bank-issued check in the mail. We cannot give cash refunds as we do not maintain a large amount of cash on the premises. Unopened product with its original seal intact will always be accepted for store credit, even without a receipt.

By signing below, you acknowledge that you have read and understood the policies and terms outlined above and you agree to abide by them:

Signature: _____ Date: _____

Printed Name: _____

I Need Help Because...

Your top priority health issue: _____

Are you being treated for this condition by anyone else? Yes No

If Yes, who? _____ Phone Number: _____

Has this condition been diagnosed by an MD? Yes (Diagnosis: _____) No

Have these treatments helped? Yes Somewhat Not much Not at all

How does this condition affect you? _____

How long have you had this condition? _____

Describe your level of pain/discomfort/misery right now:

Extreme Very High High Moderate Mild Very Mild None

Describe your level of pain/discomfort/misery when it is at its worst:

Extreme Very High High Moderate Mild Very Mild None

Describe your level of pain/discomfort/misery when it is at its best:

Extreme Very High High Moderate Mild Very Mild None

Describe the frequency and duration of your pain/discomfort/misery (check all that apply):

Constant Nearly Constant Sudden onset Comes and goes slowly

Comes and goes quickly Frequent Somewhat Frequent Infrequent Rare

Consistent Inconsistent Daily Weekly Monthly Less than monthly

Secondary health issue: _____

_____ Are you being treated for this condition by anyone else? Yes No

If Yes, who? _____ Phone Number: _____

Has this condition been diagnosed by an MD? Yes (Diagnosis: _____) No

Have these treatments helped? Yes Somewhat Not much Not at all

How does this condition affect you? _____

How long have you had this condition? _____

Describe your level of pain/discomfort/misery right now:

Extreme Very High High Moderate Mild Very Mild None

Describe your level of pain/discomfort/misery when it is at its worst:

Extreme Very High High Moderate Mild Very Mild None

Describe your level of pain/discomfort/misery when it is at its best:

Extreme Very High High Moderate Mild Very Mild None

Describe the frequency of episodes (check all that apply):

Constant Nearly Constant Frequent Somewhat Frequent Infrequent Rare None

Consistent Inconsistent Daily Weekly Monthly Less than Monthly

Any other comments on health issues you'd like us to address: _____

General Health

Do you currently have any infectious diseases? Yes No Possibly

If yes, please specify: HIV Hepatitis B Hepatitis C Flu/Cold Streptococcus Tuberculosis

Mononucleosis Other: _____

Known or suspected allergies: _____

Childhood diseases you have had: Chicken Pox Measles Mumps Rheumatic Fever Diphtheria

Scarlet Fever Other _____

Describe any accidents/hospitalizations/surgeries in the past 10 years (please give approx. dates):

What (if any) weight loss goals do you have? _____

Are you open to coaching on weight loss? Yes No Possibly

How much water do you consume daily? _____

How much caffeine do you consume daily/weekly? _____

How much alcohol do you consume daily/weekly? _____

How much recreational drugs do you consume daily/weekly? _____

Describe your daily intake of sugar:

Very High High Moderate Infrequent Rare None Unsure

Describe your daily intake of breads/grains/pasta:

Very High High Moderate Infrequent Rare None Unsure

Describe your daily intake of protein:

Very High High Moderate Infrequent Rare None Unsure

What kinds of proteins do you consume? _____

Describe your daily intake of fruits:

Very High High Moderate Infrequent Rare None Unsure

Describe your daily intake of vegetables:

Very High High Moderate Infrequent Rare None Unsure

Describe your level of weekly exercise:

Very High High Moderate Infrequent Rare None

Describe your level of weekly meditation, prayer, or quiet reflection:

Very High High Moderate Infrequent Rare None

Describe your level of weekly stress:

Very High High Moderate Infrequent Rare None

Describe your quality of sleep:

Very Good Good Okay Not Good Poor Terrible It varies

How many hours of sleep do you get on average at night?:

8 to 10 7 to 8 6 to 8 5 to 6 4 to 6 3 to 5 less than 3 It varies

Describe your daily skincare regimen:

Very Good Good Okay Not Good Poor Terrible It varies

Please indicate issues occurring in the last twelve months:

<p><u>Cardiovascular Conditions:</u></p> <input type="checkbox"/> Heart Disease <input type="checkbox"/> A Pacemaker <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitation <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Edema	<p><u>Emotional/ Mental:</u></p> <input type="checkbox"/> Clinical Depression <input type="checkbox"/> Mild Depression <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia	<p><u>Energy & Immunity:</u></p> <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> General Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Frequent Allergies <input type="checkbox"/> Excess energy <input type="checkbox"/> Other:	<p><u>Respiratory:</u></p> <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Freq. Common Colds <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath
<p><u>Musculo-Skeletal:</u></p> <input type="checkbox"/> Neck/ Shoulder Pain <input type="checkbox"/> Muscle Spasms/Cramps <input type="checkbox"/> Arm Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Other:	<p><u>Head, EENT:</u></p> <input type="checkbox"/> Eye Pain/ Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Glasses/ Contacts <input type="checkbox"/> Tearing/ Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Tension Headaches <input type="checkbox"/> Sinus Headaches <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Frequent Sore Throat <input type="checkbox"/> TMJ/ Jaw Problem <input type="checkbox"/> Hay Fever	<p><u>Genito-Urinary Tract:</u></p> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discharge <input type="checkbox"/> Incontinence	<p><u>Gastrointestinal:</u></p> <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea/ Vomiting <input type="checkbox"/> Epigastric/ Abdominal Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Belching <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea
<p><u>Endocrine:</u></p> <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweating <input type="checkbox"/> Feeling Hot or Cold <input type="checkbox"/> Other:	<p><u>Other:</u></p> <input type="checkbox"/> Cancer: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Candida <input type="checkbox"/> Anemia <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema/ Hives <input type="checkbox"/> Cold Hand/ Feet <input type="checkbox"/> Hemophilia <input type="checkbox"/> Thinning/ Graying Hair	<p><u>Neurological:</u></p> <input type="checkbox"/> Vertigo/ Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness/ Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures/ Epilepsy <input type="checkbox"/> Dyslexia <input type="checkbox"/> Poor Memory <input type="checkbox"/> Other:	<p><u>Men Only:</u></p> <input type="checkbox"/> Impotence <input type="checkbox"/> Vasectomy Date: _____ <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Testicular Pain/ Redness/ Swelling <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Seminal emissions

Women Only:

Are you pregnant right now? Yes No Trying Maybe Method of Birth Control: _____ Age at first period: _____ Date of last menses: _____ Age at menopause: _____ Typical length of menses (days): _____ Typical length of cycle (from 1st day to 1st day of menses): _____ Number of pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____

Hysterectomy: Yes No Date: _____ Check all that apply: Low libido Excessive libido Painful Intercourse Clotting Painful Periods Heavy Flow Scanty Flow Bleeding Between Cycles Irregular Cycles Vaginal Discharge Breast Lumps/ Tenderness Nipple Discharge Infertility Menopausal Symptoms Premenstrual Problems

Please list all supplements and medications you are currently taking:

MEDICATION/SUPPLEMENT	DOSAGE	PRESCRIBED BY	PURPOSE	FOR HOW LONG