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NEW PATIENT INFORMATION

(PLEASE PRINT)

Today's Date:	Last Name:		First Name:
Date of Birth: / /	Age:	Male / Female / Non-binary	Preferred Name:

Street Address:	City:	State:	Zip:
Preferred ph. (cell / wk / hm): ( ) -	email:		
Alt. phone (cell / wk / hm): ( ) -	Occupation:		

Who do you live with? no one / roommate / spouse / other: _____

Are you: Single / Married / Divorced / Widowed

Insurance Information

Do you have insurance that covers Acupuncture?	Yes / No / Not sure
Insurance Company:	

In Case of Emergency

Name:	Your relationship to this person:
Cell / wk / home phone: ( ) -	Cell / wk / home phone: ( ) -

How did you hear about us?

Please circle one

Friend / Family / Practitioner / Facebook / ATC / Georgia Sports Chiropractic

Internet Search / Morningside / IG / Nextdoor / Other _____

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Patient Name: _____

What is your main concern for seeking Acupuncture today?

Please tell us on a scale 1-4 if you have experienced any of these

1 = experienced in past year
2 = experienced in past 6 months
3 = experienced in past month
4 = experiencd in past week

Digestion:

1 2 3 4 Constipation
1 2 3 4 Diarrhea
1 2 3 4 Heart Burn
1 2 3 4 Acid reflux
1 2 3 4 Belching
1 2 3 4 Gas
1 2 3 4 Bloating
1 2 3 4 Nausea
1 2 3 4 _____
1 2 3 4 _____
1 2 3 4 _____

Eyes:

1 2 3 4 Dry eyes
1 2 3 4 Blurry vision
1 2 3 4 Poor Night Vision
1 2 3 4 _____
1 2 3 4 _____

Ears:

1 2 3 4 Ringing
1 2 3 4 Loss of hearing
1 2 3 4 Drainage / ear wax
1 2 3 4 _____

Pain:

1 2 3 4 Headaches
1 2 3 4 Ears / nose / throat
1 2 3 4 Chest
1 2 3 4 Shoulders
1 2 3 4 Neck
1 2 3 4 Back
1 2 3 4 Hips
1 2 3 4 Knees
1 2 3 4 other joints
1 2 3 4 feet

Skin:

1 2 3 4 Dry / Flaky
1 2 3 4 Oily
1 2 3 4 Hives / Rashes
1 2 3 4 Acne
1 2 3 4 Eczema

Nose:

1 2 3 4 Dry
1 2 3 4 Bloody Nose
1 2 3 4 Congested
1 2 3 4 Runny

Throat:

1 2 3 4	Infections	1 2 3 4	irritation / dry / scratchy
1 2 3 4	swelling		

Sleep:

How many hours of sleep per night do you get during the week?	<4	4-5	5-6	6-7	8-9	10+
How many hours of sleep per night do you get on the weekend?	<4	4-5	5-6	6-7	8-9	10+

Do you fall asleep easily? Y / N	Do you fall back asleep easily? Y / N
Do you wake up during night? Y / N	How many times? _____
What time do you usually go to bed?	When do you wake?
Do you Dream? Y / N	
Do you sweat easily? Y / N	Do you run hot or Cold compared to others?

Health History:

If Yes please provide details (dates, area of body etc)

Please Circle ALL that have applied or currently apply to you :

High Blood Pressure	Cancer	Smoking
Chicken Pox / measles / mumps	Mono	Hepatitis
Blod Clots	Tuberculosis	Seizures
Alcohol / Drug Addiction	stroke	Heart Condition
Asthma	Allergies	HIV / AIDS

Surgery (list year & type of surgery below)

1)

2)

3)

Female Patients only:

Are you or could you be pregnant?	Y / N	
Start of last menstrual Cycle: / /	# of days in Cycle:	# of flow days?
Cramping? None / Mild / Moderate / Severe	Clots? Y / N	
# of pregnancies?	# of children:	

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Please list all Supplements and / or Medications you are currently taking

Supplement Name	Dosage / day	How long have you been taking?	Reason for taking?

Medication Name	Dosage / day	How long have you been taking?	Reason for taking?

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Core Health and Wellness Acupuncture, LLC

By signing below you acknowledge you have received and read a copy of Core Health and Wellness Acupuncture, LLC HIPAA Privacy Policy.

Patient Name: _____

Signature: _____ Date: _____

As it relates to sharing your health information, **please initial ONE** of the following choices, complete the information, if applicable, and sign.

_____ At this time, do not share my health information to anyone, except for purposes outlined in the HIPAA Privacy Policy.

_____ I give you permission to share & discuss my health and treatment information with the following people:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient Name: _____

Signature: _____ Date: _____

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Cancellation, Rescheduling & Missed Appointments Policy

As a courtesy to other patients and the practitioner's time, if you should need to cancel or change your appointment time, please notify us at least 48 hours before your scheduled appointment time. Since we are closed Saturday and Sunday, if you need to cancel or make a change to a Monday appointment, please do no later than Thursday before. If you do not show up for an appointment, cancel or reschedule within the 48 hour timeframe of your appointment, you will be charged $75.

As a courtesy to other patients and the practitioner's time, please do your best to arrive on time for your appointment. As the practitioner, I will do my best to keep to my schedule and be ready for you at your scheduled appointment time. If you are running more than 5-10 minutes late, please call or text me, so I can determine if there will be enough time to still treat you. If you are running so late that there is not enough time to treat you, you will have to reschedule and may be charged $75, same as a missed or cancelled appointment.

Patient name (printed): _____

Patient Signature: _____ Date: _____

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Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of Acupuncture treatments and other procedures within the scope of the practice of Acupuncture on me (or the patient named below, for when I am legally responsible) by the Acupuncturist indicated below and/or other licensed Acupuncturist(s) 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 treatment may include, but are not limited to, Acupuncture, Moxibustion, Cupping, electrical stimulation, Tui-Na (chinese massage), Chinese Herbal Medicine and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instruction provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff or any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that Acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scaring are a potential risk of moxibustion and cupping, or when treatments involves the use of heat lamps. Marks that look similar to bruising is a common side effect of cupping. Unusual risks of Acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic only used sterile disposable needles and maintain a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe run 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 or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all the possible risks and complications of treatments, 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 then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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 treatment.

Acupuncturist Name: Jennifer Myers, Dipl.Ac. L.Ac.

Patient Signature **X** _____ Date: _____

(or patient representative, indicate relationship if signing for patient)

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Who else is currently on your wellness team?

* we will not share your health information without your permission *

Circle one:
General Physician / OB-GYN / Fertility Dr / Chiropractor / Massage Therapist /
Physical Therapist / Oncologist / Speciality (please specify) ________________

Practitioner / clinic Name : ____

Location: ________________________________ Phone #: ________________________

Circle one:
General Physician / OB-GYN / Fertility Dr / Chiropractor / Massage Therapist /
Physical Therapist / Oncologist / Speciality (please specify) ________________

Practitioner / clinic Name : ____

Location: ________________________________ Phone #: ________________________

Circle one:
General Physician / OB-GYN / Fertility Dr / Chiropractor / Massage Therapist /
Physical Therapist / Oncologist / Speciality (please specify) ________________

Practitioner / clinic Name : ____

Location: ________________________________ Phone #: ________________________

Circle one:
General Physician / OB-GYN / Fertility Dr / Chiropractor / Massage Therapist /
Physical Therapist / Oncologist / Speciality (please specify) ________________

Practitioner / clinic Name : ____

Location: ________________________________ Phone #: ________________________