

**\*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

Your Insurance Provider? \_\_\_\_\_

We can provide you with a questionnaire to fill out in order to for you to determine insurance coverage for yourself, or we can contact your insurance provider for you.

Would you like us to check your insurance for coverage?  Yes  No  Provide me with questionnaire

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):

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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><b><u>Cardiovascular Conditions:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Heart Disease</li> <li><input type="checkbox"/> A Pacemaker</li> <li><input type="checkbox"/> High Blood Pressure</li> <li><input type="checkbox"/> Low Blood Pressure</li> <li><input type="checkbox"/> Chest Pain</li> <li><input type="checkbox"/> Palpitation</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Varicose Veins</li> <li><input type="checkbox"/> Edema</li> </ul>	<p><b><u>Emotional/ Mental:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Clinical Depression</li> <li><input type="checkbox"/> Mild Depression</li> <li><input type="checkbox"/> ADD or ADHD</li> <li><input type="checkbox"/> Schizophrenia</li> <li><input type="checkbox"/> Mood Swings</li> <li><input type="checkbox"/> Panic Attacks</li> <li><input type="checkbox"/> Nervousness</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Alzheimer's</li> <li><input type="checkbox"/> Dementia</li> </ul>	<p><b><u>Energy &amp; Immunity:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic Fatigue Syndrome</li> <li><input type="checkbox"/> General Fatigue</li> <li><input type="checkbox"/> Slow Wound Healing</li> <li><input type="checkbox"/> Easy Bruising</li> <li><input type="checkbox"/> Chronic Infections</li> <li><input type="checkbox"/> Frequent Allergies</li> <li><input type="checkbox"/> Excess energy</li> <li><input type="checkbox"/> Other:</li> </ul>	<p><b><u>Respiratory:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Freq. Common Colds</li> <li><input type="checkbox"/> Difficulty Breathing</li> <li><input type="checkbox"/> Emphysema</li> <li><input type="checkbox"/> Persistent Cough</li> <li><input type="checkbox"/> Pleurisy</li> <li><input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> Shortness of Breath</li> </ul>
<p><b><u>Musculo-Skeletal:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Neck/ Shoulder Pain</li> <li><input type="checkbox"/> Muscle Spasms/Cramps</li> <li><input type="checkbox"/> Arm Pain</li> <li><input type="checkbox"/> Upper Back Pain</li> <li><input type="checkbox"/> Mid Back Pain</li> <li><input type="checkbox"/> Low Back Pain</li> <li><input type="checkbox"/> Leg Pain</li> <li><input type="checkbox"/> Osteoporosis</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Joint Pain</li> <li><input type="checkbox"/> Other:</li> </ul>	<p><b><u>Head, EENT:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Eye Pain/ Strain</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Glasses/ Contacts</li> <li><input type="checkbox"/> Tearing/ Dryness</li> <li><input type="checkbox"/> Impaired Hearing</li> <li><input type="checkbox"/> Ear Ringing</li> <li><input type="checkbox"/> Earaches</li> <li><input type="checkbox"/> Tension Headaches</li> <li><input type="checkbox"/> Sinus Headaches</li> <li><input type="checkbox"/> Sinus Congestion</li> <li><input type="checkbox"/> Nose Bleeds</li> <li><input type="checkbox"/> Teeth Grinding</li> <li><input type="checkbox"/> Frequent Sore Throat</li> <li><input type="checkbox"/> TMJ/ Jaw Problem</li> <li><input type="checkbox"/> Hay Fever</li> </ul>	<p><b><u>Genito-Urinary Tract:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Kidney Disease</li> <li><input type="checkbox"/> Kidney Stones</li> <li><input type="checkbox"/> Painful Urination</li> <li><input type="checkbox"/> Dribbling Urination</li> <li><input type="checkbox"/> Frequent UTI</li> <li><input type="checkbox"/> Frequent Urination</li> <li><input type="checkbox"/> Blood in Urine</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Incontinence</li> </ul>	<p><b><u>Gastrointestinal:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Stomach Ulcers</li> <li><input type="checkbox"/> Changes in Appetite</li> <li><input type="checkbox"/> Nausea/ Vomiting</li> <li><input type="checkbox"/> Epigastric/ Abdominal Pain</li> <li><input type="checkbox"/> Passing Gas</li> <li><input type="checkbox"/> Heartburn</li> <li><input type="checkbox"/> Belching</li> <li><input type="checkbox"/> Gallbladder Disease</li> <li><input type="checkbox"/> Gall Bladder Stones</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> </ul>
<p><b><u>Endocrine:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hypothyroid</li> <li><input type="checkbox"/> Hypoglycemia</li> <li><input type="checkbox"/> Hyperthyroid</li> <li><input type="checkbox"/> Diabetes Type I</li> <li><input type="checkbox"/> Diabetes Type II</li> <li><input type="checkbox"/> Night Sweats</li> <li><input type="checkbox"/> Unusual Sweating</li> <li><input type="checkbox"/> Feeling Hot or Cold</li> <li><input type="checkbox"/> Other:</li> </ul>	<p><b><u>Other:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cancer: _____</li> <li><input type="checkbox"/> Fibromyalgia</li> <li><input type="checkbox"/> Lupus</li> <li><input type="checkbox"/> Candida</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Rashes</li> <li><input type="checkbox"/> Eczema/ Hives</li> <li><input type="checkbox"/> Cold Hand/ Feet</li> <li><input type="checkbox"/> Hemophilia</li> <li><input type="checkbox"/> Thinning/ Graying Hair</li> </ul>	<p><b><u>Neurological:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Vertigo/ Dizziness</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Numbness/ Tingling</li> <li><input type="checkbox"/> Loss of Balance</li> <li><input type="checkbox"/> Seizures/ Epilepsy</li> <li><input type="checkbox"/> Dyslexia</li> <li><input type="checkbox"/> Poor Memory</li> <li><input type="checkbox"/> Other:</li> </ul>	<p><b><u>Men Only:</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Impotence</li> <li><input type="checkbox"/> Vasectomy</li> <li>Date: _____</li> <li><input type="checkbox"/> Prostate Problems</li> <li><input type="checkbox"/> Testicular Pain/ Redness/ Swelling</li> <li><input type="checkbox"/> Low libido</li> <li><input type="checkbox"/> Excessive libido</li> <li><input type="checkbox"/> Painful intercourse</li> <li><input type="checkbox"/> Seminal emissions</li> </ul>

**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 1<sup>st</sup> day to 1<sup>st</sup> 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

# Cancellation & Returns Agreement

## CANCELLATION & RESCHEDULING POLICY

You may cancel or reschedule an appointment with no charge any time before the close of business (5pm) 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 100% of the scheduled service's regular price.**

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 and have no unused treatment credits purchased from [www.healinghouse.com](http://www.healinghouse.com). By signing below, you authorize this payment under the conditions outlined above.

If you have an unused treatment credit that you purchased directly from Healing House, such as from a voucher, package, or a membership, we will apply that credit to cover your cancelled, missed, or rescheduled appointment.

If you are a member at Healing House and you do not have a pre-paid treatment credit, we will charge you the membership rate for your missed or rescheduled appointment.

**Gift certificates or treatment credits purchased from any website other than [www.healinghouse.com](http://www.healinghouse.com) cannot be applied to cover missed, cancelled, or rescheduled appointments.**

## 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:**

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

