healing house
IN SCOTTSDALE

Muki Ramsey, L.Ac.

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

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