Journey of the Phoenix Wellness Center
Information and Consent to Services

I have read and understand the entirety of this form and acknowledge that the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of the service(s) to be performed have been explained to me. I understand I am free to discontinue services at any time for any reason.

To be signed before any services are provided.

I hereby voluntarily consent to:
Please initial all that apply _____ Acupuncture Treatment _____ Herbal Consultation _____ Massage/Bodywork

[ ]Mr. [ ] Mrs. [ ]Ms. _____
PRINTED NAME OF CLIENT

_____ ADDRESS

_____ DATE OF BIRTH (MM/DD/YYYY)

_____ CITY, STATE, ZIP CODE

_____ EMAIL ADDRESS

_____ HOME PHONE

_____ MOBILE PHONE

_____ WORK PHONE

_____ PREFERRED METHOD OF CONTACT

_____ SIGNATURE OF CLIENT (parent or guardian for minors)

_____ DATE

Acupuncture

Services Provided

I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand that I may be treated with the application of heat to the skin.

Risks/ Possible Side Effects

I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and/or discomfort, and aggravation of symptoms existing prior to treatment.

Herbal Consultations

Services Provided

I understand that herbs are considered to be food supplements and are utilized to strengthen and support overall health and wellness. Herbs along with nutrition suggestions can serve as an excellent adjunct to a medical doctor's treatment, but are not a substitution for that treatment . An herbalist can neither diagnose nor treat a disease.

Risks/ Possible Side Effects

side effects

I understand that historical records and modern research indicate that the herbs most often used for healthcare have an exceptional safety record. However, adverse reactions and unintended side effects can sometime occur when taking herbs. Side effects that have occasionally been reported after using herbs include, headache, skin rash, and digestive upsets. Such effects generally resolve rapidly, especially if the dosage is reduced or the herb is stopped. Allergic reactions are also very rare but have been reported, usually in individuals with contact allergy to specific plants. Should adverse reactions occur, I agree to discontinue taking the herbs and

[Information continues to the next page]

my herbalist as soon as possible. My herbalist may be able to propose measures to reduce any discomfort or may refer me to a physician or other healthcare practitioner.

Herb-Drug Interactions
Although herbs and other supplements have the potential to interact with pharmaceuticals and certain herbs have been shown to have some effect on a limited range of pharmaceuticals, clinically significant interactions between most herbs and prescribed drugs are rare or only potentially possible in theory. Nevertheless, some prescribed drugs are very strong and have a narrow range of safe dosage, which makes any interaction more risky. It is the responsibility of the clients to disclose fully any medication currently in use, including other herbs and supplements. Clients also are expected to inform their physicians of any herbs or supplements they are using. Any indication that the effect of a drug is being altered by simultaneous use of an herb should be reported directly to all health professionals involved. It is also advisable to stop taking herbs at least 48 hours before a surgical operation, and in the event of being prescribed anticoagulants, anti-epileptic drugs, and digoxin until the expert advice is received.

Toxicity
All of the herbs that we use are generally considered safe and non-toxic at recommended doses for most people; however, it is important that the client used the herbs in accordance with the dosage recommended by the herbalist. Because the liver and the kidneys are the body organs most vulnerable to any ingested or absorbed substance, it is also important that the client disclose to the herbalist any past or current diseases in either of these organs. Herbs should not be used in pregnancy or lactation without advice of a healthcare practitioner, and clients who become pregnant should stop taking herbs until that advice is received. I understand and agree that it is important that I do not exceed the recommended dose of the herbs suggested by my herbalist. I also understand and agree to disclose to my herbalist any previous or current liver or kidney disease or related disease as well as any other condition that I believe may have an Impact on my health status.

Massage/Bodywork

Services Provided
I understand that the massage/bodywork I may receive is for the basic purpose of relaxation and relief of muscle tension.

Risks/ Possible Side Effects
I understand that I may experience pain or discomfort from a massage/bodywork. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I will not hold the practitioner responsible for any discomfort or reaction I may experience.

Information and Disclosures

Infectious Disease Prevention
I understand that infectious diseases are spread through the air, through physical contact, and through body fluids. I understand that Copper Penny Acupuncture, LLC follows universally prescribed precautions and procedures (such as clean needle technique and hand washing) to prevent the spread of disease.

No Guarantees
I understand that each person is unique and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from the services provided.

Client Responsibilities
I understand that it is my responsibility as a client to inform my practitioner of all aspects of my health and that, as service progresses, to inform my practitioner of changes that occur. I will inform my practitioner if I am pregnant and/or suspect pregnancy at any time. if I experience any pain, discomfort, or possible adverse side effects, it is my responsibility to immediately notify my practitioner. It is my responsibility to obtain a physical exam from a physician within 60 days prior to seeking treatment or within 60 days of starting treatment with an acupuncturist.

Medical Treatment
I understand that an acupuncturist is not a substitute for a medical doctor. A licensed acupuncturist will not suggest that I discontinue medical treatment. I understand that if I am currently under a physician's care, I should continue as long as my physician deems necessary. It is my responsibility to consult with my physician before altering any medications or medical treatments. I understand that Copper Penny Acupuncture, LLC may request a physical exam within the first 60 days if it has been over 60 days since my last physical exam. I am free to consult a medical doctor or any other licensed practitioner at any time. I understand also that if there is an emergency, or a worsening of my health conditions or if a new ailment or condition arises, that I should consult a licensed physician.

Fees and Charges

I have been informed of the fees for service. I understand that payment is due when the services are provided. I understand that if I do not cancel my appointment at least 24 hours in advance, then I am liable for the fee.

Patient Intake Form

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Identification

Name_____ Date_____ Sex [ ]M [ ]F

Address_____ City_____ State____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Date of Birth _____ Age_____ Email_____

[ ]Single [ ]Married [ ]Partnered [ ]Widowed [ ]Separated [ ]Divorced

Height_____ Weight_____ Occupation_____

Education _____

Emergency Contact_____ Relation _____

Emergency Contact: Home Phone_____ Cell_____

Name of Physician* _____

Phone Number _____ Date last seen _____

Address_____ City_____ State____ Zip_____

Name of Counselor/Psychologist* _____

Phone Number _____ Date last seen _____

Address_____ City_____ State____ Zip_____

Name of Gynecologist* _____

Phone Number _____ Date last seen _____

Address_____ City_____ State____ Zip_____

*No contact will be made without your consent.

Your Signature_____

Special problems or symptoms _____

_____

Family History Please complete for each family member, as best as you can, indicating any illness that they or you have ever had. Place an "X" or date in the appropriate box(es).

	self (date)	mother	father	sibling	spouse/partner	children
good health						
adopted						
cancer or tumors						
diabetes						
thyroid disorders						
kidney disorders						
high blood pressure/heart disease stroke						
seizures						
allergies						
alcohol or drug use						
depression or mental illness						
hepatitis or other liver disorders						
musculo-skeletal disorders						
HIV/AIDS						
Deceased						

Personal Lifestyle Habits

Please indicate how much, how many, or how often. Please circle day or week and mark quit date if it is not a current habit.

Exercise [ ]yes [ ]no How often?_____ What type?_____

Smoking (packs per day/week)_____ Alcohol (drinks per day/week)_____

Recreational Drug use (Type)_____ Coffee (cups per day/week)_____

Soda(diet/regular) (cups per day/week)_____ Tea (cups per day/week)_____

Medical History and Medicines Please mark any hospitalization including operations, trips to the ER, or major illnesses.

Year Operation/Illness Hospital or treatment location

_____

_____

_____

_____

Medication/vitamin/supplement Dosage For what purpose?

_____

_____

_____

_____

Please attach a list of any other medications.

Current and Past Conditions/Symptoms/Traumas If you are currently experiencing any of the following, please mark with a "C" for current or "P" for past or "PC" for both.

General
_____ Insomnia
_____ Dreams/Nightmares
_____ Fatigue
_____ Poor memory
_____ Desire for cold drinks
_____ Desire for hot drinks
_____ Recent weight gain/ lost
_____ Cold hands/feet
_____ Chills
_____ Fever
_____ Bad breath
_____ Other (describe)

_____

Head & Neck
_____ Headaches
_____ Migraines
_____ Stiff neck
_____ Dizziness
_____ Fainting
_____ Swollen glands
_____ Other (describe)

_____

Ears
_____ Ringing
_____ Hearing loss
_____ Hearing aids
_____ Infection
_____ Earache
_____ Vertigo
_____ Other (describe)

_____

Eyes
_____ Glasses/contacts
_____ Blurred vision
_____ Poor night vision
_____ Spots or floaters
_____ Eye inflammation/dryness
_____ Double vision
_____ Glaucoma
_____ Cataracts
_____ Lazy eye
_____ Other (describe)

_____
Last eye appointment?
_____

Nose, Throat & Mouth
_____ Sinus Infection
_____ Hay fever/ allergies
_____ Frequent sore throat
_____ Difficulty swallowing
_____ Mouth or tongue ulcers
_____ Frequent colds
_____ Nosebleeds
_____ Dry nose
_____ Nasal congestion
_____ Loss of voice
_____ Thirst
_____ Excessive phlegm
_____ TMJ
_____ Facial pain
_____ Gum problems
_____ Dry mouth
_____ Other(describe)

_____
_____ Dental Problems/Last visit

_____

Skin
_____ Hives
_____ Rashes
_____ Eczema/ Psoriasis
_____ Night sweating
_____ Excess sweating
_____ Dry skin
_____ Easily bruised
_____ Changes in moles, lumps
_____ Itching
_____ Other (describe)

_____

Respiratory
_____ Difficulty breathing
_____ Hard to breathe if reclined
_____ Wheezing
_____ Asthma
_____ Chronic cough
_____ Wet cough
_____ Dry cough
_____ Coughing up blood
_____ Coughing up phlegm
_____ Shortness of breath
_____ Tight chest
_____ Pneumonia
_____ Other (describe)

_____

Cardiovascular
_____ High blood pressure
_____ Low blood pressure
_____ Chest pain or tightness
_____ Palpitation
_____ Rapid heart beat
_____ Irregular heart beat
_____ Poor circulation
_____ Swollen ankles
_____ Phlebitis
_____ Anemia
_____ History of heart disease
_____ Heart murmur
_____ Night sweats
_____ Tendency to be warm
_____ Tendency to be cold
_____ Other (describe)

_____

Gastrointestinal
_____ Nausea
_____ Indigestion
_____ Stomach pain
_____ Diarrhea
_____ Constipation
_____ Poor appetite
_____ Excessive hunger
_____ Vomiting
_____ Gas
_____ Hiccups
_____ Acid regurgitation
_____ Bloating
_____ Laxative use
_____ Bloody stool
_____ Other (describe)

_____

Musculoskeletal
_____ Joint pain/swelling
_____ Sore muscles
_____ Weak muscles
_____ Difficulty walking
_____ Pain (describe)

_____
_____
_____
_____ Limited range of motion
_____ Other (describe)

_____

Neurological
_____ Seizures
_____ Tremors
_____ Numbness or tingling
_____ Pain
_____ Paralysis
_____ Poor coordination
_____ Other (describe)

_____

Mental/Emotional
_____ Depression
_____ Mood swings
_____ Irritability
_____ Difficulty relaxing
_____ Loneliness
_____ Sensitive
_____ Shyness
_____ Frequent crying
_____ Frequently worrying
_____ Compulsive behaviors
_____ Difficulty focusing
_____ Hopeless outlook
_____ Suicidal thoughts
_____ Lose temper
_____ Frustration
_____ Other(describe)

_____

Urinary
_____ Painful urination
_____ Frequent urination
_____ Urgent urination
_____ Blood in urine
_____ Incontinence
_____ Incomplete urination
_____ Bedwetting
_____ Wake to urinate
_____ History of UTI
_____ Kidney (describe)
_____
_____
_____ Other(describe)

_____

Male Genital
_____ Impotence
_____ Premature ejaculation
_____ Nocturnal emissions
_____ Pain/Itching of genitalia
_____ Testicular lumps
_____ Increased libido
_____ Decreased libido
_____ Other (describe)

_____

Gynecology (Females)
_____ Currently pregnant
_____ # of pregnancies
_____ # of live births
_____ # of miscarriages
_____ # of abortions
_____ Menopause
_____ Irregular periods
_____ Menstrual cramps
_____ Excessive blood flow
_____ Menstrual blood clots
_____ Breast tenderness
_____ Abnormal Pap smear
_____ Vaginal infection
_____ Vaginal pain/itching
_____ Uterine fibroids
_____ Ovarian cysts
_____ Endometriosis
_____ Breast lumps/cysts
_____ Increased libido
_____ Decreased libido
_____ Other (describe)

_____

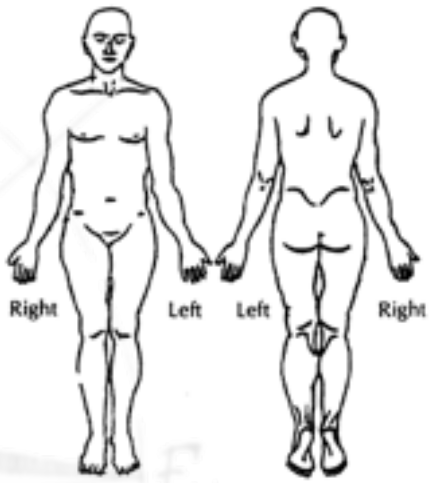
Infections (circle self or partner)
_____ HIV (Self/Partner)
_____ TB (Self/Partner)
_____ Hepatitis (Self/Partner)
_____ STD(s) (Self/Partner)
(Specify)
_____
_____
_____ Other(describe)

_____

Trauma (list)
_____
_____
_____
_____
_____
_____

Other Information
_____
_____
_____
_____
_____
_____

_____
_____
_____
_____
_____
Please mark areas of pain.



Acupuncture Clinic Fees
Initial traditional diagnosis $100
Follow-up treatment $70

Chinese Herbal Clinic Fees
Initial consultation $70
Add acupuncture $110
Follow-up consultation $55
Add acupuncture $85

Policies and Fees

Cancellation without 24 hours notice / more than 15 mins late / no show will result in Full charge of appointment plus a credit card placed on file.
Returned Check Fee $40

We prefer cash or check, and accept major credit cards, FSAs, and HSAs.

I understand the fees associated with my appointment and/or missed appointments.

_____/___/___
Patient Signature Date