Phoenix Healing Initial Intake Form

Today's date _____/_____/_____

Thank you for taking the time to complete the following information which will help me assess your health needs. All information is confidential. I will be happy to answer any questions.

General Information

Name_____Birthdate_____/_____/_____Age_____Gender_____

Address_____City_____State____Zip_____ Phone numbers (please mark * next to best number):
Home_____Cell_____Work_____ E-mail address_____(email is necessary for us to schedule appointments using our confidential online scheduling system)
Would you like to receive our e-newsletter with supportive health information (only once per season)? ▫ Y ▫ N

Marital Status_____# of children _____
their age(s)_____ Your Educational level _____
Occupation _____Hrs per week_____
Employer & commute time _____
Health Insurance Co._____
How did you hear about us? _____
If via person, name:_____ May we send a thank you card? ▫ Y ▫ N

Emergency Contact
Name_____Ph_____
Relationship_____

Under 18 ---Responsible Party Information Name_____
Relationship to Patient_____

Healthcare Providers ---please list those you work with. Physicians:
GP/Primary Care: _____ seeking one? ▫ Y ▫ N
OB-GYN: _____ seeking one? ▫ Y ▫ N
Specialist (describe): _____ seeking one? ▫ Y ▫ N
Chiropractor: _____ seeking one? ▫ Y ▫ N
Massage Therapist:_____ seeking one? ▫ Y ▫ N
Physical Therapist:_____ seeking one? ▫ Y ▫ N
Psychotherapist:_____ seeking one? ▫ Y ▫ N

Personal Trainer:_____ seeking one? ▫ Y ▫ N
Midwife:_____ seeking one? ▫ Y ▫ N
Other:_____
May I contact these providers to ensure coordination of your care? ▫ Y ▫ N
Previous experience with acupuncture? ▫ Y ▫ N
With whom and results_____

Health History Please list your major health concerns in order of importance to you:
_____
_____
_____
_____

Check those that apply to your past medical history:
Adverse reaction to medical treatment ▫ Alcoholism ▫ Allergies ▫ Arthritis or rheumatism ▫ Asthma ▫ Attempted suicide ▫ Birth Trauma ▫ Bleeding disorder ▫ Blood disease ▫ Cancer or tumor ▫ Diabetes ▫ Emphysema ▫ Eating disorder ▫ Fibromyalgia ▫ Heart disease ▫ Hepatitis/ Liver disease ▫ Herpes ▫ High blood pressure ▫ HIV/AIDS ▫ Immune disorder ▫ Joint replacement ▫ Kidney disorder ▫ Low blood pressure ▫ Lyme's disease ▫ Lymph nodes removed ▫ Mental illness ▫ Multiple Sclerosis ▫ Pacemaker ▫ Polio ▫ Rheumatic arthritis ▫ Rheumatic fever ▫ Sciatica ▫ Scarlet fever ▫ Seizures/Epilepsy ▫ Sinus infections ▫ Skin disease ▫ Special diet ▫ Stroke ▫ Substance abuse ▫ Thyroid disease ▫ Tuberculosis ▫ Ulcer ▫ Venereal Disease/ STD ▫ Other_____ List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:
_____
_____
_____
Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, injury, family death, bankruptcy, etc).
Date____/_____Event_____
Date____/_____ Event_____
Date____/_____Event_____

Family History (List any family physical or mental illnesses and age of death):
Mother_____
Father_____
Grandparents_____
Siblings_____
Children_____

Medications, Herbs, Supplements (List those you are currently taking):
Name_____Reason _____
How long and Dose_____

Name_____Reason _____
How long and Dose_____
Name_____Reason _____
How long and Dose_____

Lifestyle Habits Describe your typical daily diet:
Breakfast_____
Lunch_____
Dinner_____
Snacks_____
Special diet_____
3 worst foods you eat_____

What is the major source of joy in your life? _____
_____
_____
What is the major source of stress in your life? _____
_____
_____

Please circle your level of commitment to correcting your health issues? (10 = highest level)
1 2 3 4 5 6 7 8 9 10

Treatment Terms and Conditions

The following are specific policies that will govern our work together:

Cancellation Policy: In the event that you must cancel an appointment, please give us the courtesy of as much notice as you can, but at least 24 hours notice (you can change and cancel appointments through our online scheduling system up to 48 hours in advance). You will be charged $40 for your session if you do not show up for your appointment or cancel your appointment with less than 24 hours notice.

Late Policy: If you are going to be late, please call and let us know and we will wait until the time we agree upon. If you do not give notice, we will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then your appointment will be cancelled and you will be responsible for the full payment of the session.

Phone Calls and Emails: You may phone or email us when necessary and we will respond as soon as possible, or within 24 hours. We are generally unavailable on weekends. Except for emergencies, phone and email contacts are limited to 5-10 minutes of our time. All contacts that require beyond 10 minutes of our time are considered session work and will be billed a flat rate of $40.

Confidentiality and Privacy Practices: As a health care provider, we are required by law to maintain and protect the confidentiality of your health information. You must give us written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other healthcare professionals. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.
Your rights to privacy regarding your protected health information: • You may request restrictions on your disclosures. • You may inspect and receive copies of your records within 30 days with a request. • You may request to view changes to your records.

Please note that we may contact you for appointment reminders, birthdays & seasonal greetings, specials, announcements, and to inform you about our practice and its staff. A more complete description of our privacy practices can be requested.

Fees It is our policy that you pay the entire session fee or co-pay at the time of each session. If you would like to arrange another payment option, please discuss it with us. We will provide a minimum of one month's notice of any changes to our fees. We are partners in your healthcare. Your participation in your healing process is crucial. Our goal is to get you well as soon as possible, which requires that you apply our health recommendations and comply with our treatment plan.

Agreement I have read and understood Phenix Healing's policies. I agree to the all of the above treatment terms and conditions.

Signature: _____ Date: _____

Phoenix Healing Informed Consent and Disclosure

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, herbal medicine, moxibustion, cupping, electrical stimulation, Reiki Energy Healing, massage, gua sha, heat therapy, ear seeds, dietary advice, qigong exercise prescriptions, and lifestyle counseling.

I understand that these therapies are safe methods of treatment. As with all medical procedures, they involve potential but unlikely risks. Such uncommon risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very, very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible but highly unlikely (we've never witnessed this), as the clinic uses alcohol, sterile disposable needles, and a safe and clean environment. A burn is a possible but extremely rare side effect of moxibustion. Temporary bruising (not painful) or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of the success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, anti-depressants, and illegal drugs.

Acupuncture is a natural medicine that works with the body's ability to heal itself, but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions. Regular treatment and completing the prescribed treatment plan are what give acupuncture and herbs the best results.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible but rare side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, and hives. I understand that I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

_____

Patient Signature Date