**Ancient Wisdom**
**Acupuncture and Wellness**

# Your Facts A1

**Last Name:** ______________ **First Name:** ______________ **Middle Initial:** ______

**Address:** ______________________________ **Apartment #:** ______

**City:** ______________ **State:** ______________ **Zip:** ______

**Home #:** ______________ **Cell #:** ______________

**Email:** ______________________________

**How did you find us?** Patient *(who)*: ________ Doctor *(who)*: ________ Staff *(who)*: ________

*(circle one)* Promotion/Event Internet Newspaper Signage Business Insurance Other: ________

**Date of Birth:** ____/____/____ **Gender** (*circle one*): Male Female **Marital Status** (*circle one*): M D W S

**Employer:** ______________ **Work #:** ______________ **Ext:** ______

**Emergency Contact:** ______________ **Relationship:** ________ **Phone #:** ________

**Primary Care Physician** (PCP): ______________ **Phone #** (PCP): ______________

**Are you currently taking any medications or supplements?** (*Please include regularly used over the counter medications)*............................

| Medication Name | Dosage and Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

| Supplement Name | Dosage and Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Do you have any medication, food, or environment allergies?**

| Medication, Food or Location | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Please list 3 major health goals in order of priority:**

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| Recreational Activities, Sports Played, Hobbies | | |
|---|---|---|
| 1. ______ | ☐ past | ☐ present |
| 2. ______ | ☐ past | ☐ present |
| 3. ______ | ☐ past | ☐ present |

A2

☐ **I do not want to know more about the benefits of becoming a Wellness Client.**

☐ **I choose to decline receipt of my clinical summary after every visit.** *(These are often blank as a result of the nature/frequency of chiropractic care)*

## FOR OFFICE USE ONLY

**Height:** ______ **Weight:** ______ **Blood Pressure:** ____/____ **Blood-type:** O A B AB

**Doctor seen on this date** (*circle all that apply*): MR SC SM SN SP ST

**Documentation** (*circle all that apply*): Scanned In Demo Entered Meds Entered Ins. Entered

## CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my medical information by Ancient Wisdom Acupuncture and Wellness - Shamayne Tate and/or the affiliate practitioners that operate within Your Wellness Connection, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Ancient Wisdom Acupuncture and Wellness - Shamayne Tate. I understand that diagnosis or treatment of me by Ancient Wisdom Acupuncture and Wellness - Shamayne Tate may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. Ancient Wisdom Acupuncture and Wellness - Shamayne Tate is not required to agree to the restrictions that I may request. However, if Ancient Wisdom Acupuncture and Wellness - Shamayne Tate agrees to a restriction that I request, the restriction is binding on Ancient Wisdom Acupuncture and Wellness - Shamayne Tate. I have the right to revoke this consent, in writing, at any time, except to the extent Ancient Wisdom Acupuncture and Wellness - Shamayne Tate has taken action in reliance on this consent.

My "medical information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This medical information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Ancient Wisdom Acupuncture and Wellness - Shamayne Tate's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of Your Welness Connection.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of Ancient Wisdom Acupuncture and Wellness - Shamayne Tate. This Notice of Privacy Practices also describes my rights and the duties of Ancient Wisdom Acupuncture and Wellness - Shamayne Tate with respect to my medical information. Ancient Wisdom Acupuncture and Wellness - Shamayne Tate reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

*This includes the consent to consult with your current, past and future providers outside Ancient Wisdom Acupuncture and Wellness - Shamayne Tate about your care, conditions and treatment plans.

______________________________ **Today's Date:** ____/____/____

**Patient or Personal Representative Signature:**

______________________________

**Printed Name of Patient or Personal Representative:**

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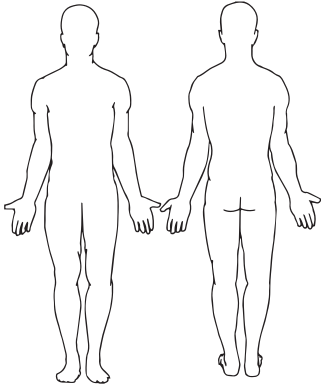
# Your Consultation A3

**Name:** ____________________ **Date of Birth:** ____________ **Date:** ____________

**Pain Location**



**Front** **Back**

## Present Condition

*List conditions in order of concern and mark location of pain.*

(minor) **Pain Scale** (extreme)
1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Has condition changed since onset? ☐ Yes ☐ No ☐ Better ☐ Worse

Explain: ____________________

What makes pain better? ____________________

Worse? ____________________

Difficult activities: ____________________

## Who Have You Seen:

***Who have you seen for your symptoms, and when?*** ***Date***

Chiropractor: ____________________

Medical Doctor: ____________________

Physical Therapist: ____________________

Other: ____________________

## Have You Had:

| | | | |
|---|---|---|---|
| Blood analysis | ☐ Yes | ☐ No | ________ When |
| Blood pressure check | ☐ Yes | ☐ No | ________ When |
| Bone density | ☐ Yes | ☐ No | ________ When |
| Eye exam | ☐ Yes | ☐ No | ________ When |
| Feelings of hopelessness | ☐ Yes | ☐ No | ________ When |
| Feelings of depression | ☐ Yes | ☐ No | ________ When |
| Feelings of anxiety | ☐ Yes | ☐ No | ________ When |
| Feelings of panic | ☐ Yes | ☐ No | ________ When |
| MRI | ☐ Yes | ☐ No | ________ When |
| Spinal x-ray | ☐ Yes | ☐ No | ________ When |

## Current Symptoms

**1**
- ☐ Knee Pain
- ☐ Leg Cramps
- ☐ Numbness in Toes
- ☐ Tingling in Legs
- ☐ Weakness In Legs

**2**
- ☐ Urinating Issues
- ☐ Lower Back Pain
- ☐ Ringing in Ears

**3**
- ☐ Bladder Infections
- ☐ Belching
- ☐ Constipation
- ☐ Indigestion
- ☐ Vomiting

**4**
- ☐ Arm Pain
- ☐ Circulatory Problems
- ☐ Hands Cold
- ☐ Mid-Back Pain
- ☐ Numbness in Fingers
- ☐ Shortness of Breath
- ☐ Shoulder Pain
- ☐ Tingling in Arms

**5**
- ☐ Back Pain
- ☐ Dizziness
- ☐ Hair Loss
- ☐ Hay fever
- ☐ Hives
- ☐ Loss of Balance/Dizzy
- ☐ Neck Pain/Stiffness
- ☐ Nervousness

**6**
- ☐ Bruise Easily
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Frequent Colds
- ☐ Hemorrhoids
- ☐ Loss of Smell/Taste
- ☐ Muscle Spasms
- ☐ Sight Sensitivity
- ☐ Sinus Problems

**7**
- ☐ Cold/Hot Sweats
- ☐ Fatigue
- ☐ Fever
- ☐ Joints Swelling/Pain
- ☐ Sleep Problems
- ☐ Stress
- ☐ Other ____________
- ☐ Other ____________
- ☐ Other ____________

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ancientwisdom.tate@gmail.com | (913) 962-7408 (office) | www.YourWellnessConnection.com | 7410 Switzer, Shawnee, KS 66203

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# Your History A4

**Name:** ______________________ **Date of Birth:** ______________ **Date:** ______________

## Medical History

| | Self | Siblings | Mom | Dad | GPs |
|---|---|---|---|---|---|
| ADD/ADHD | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alcohol | ☐ | ☐ | ☐ | ☐ | ☐ |
| Allergies | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis - *Type* ________ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Birth Trauma | ☐ | ☐ | ☐ | ☐ | ☐ |
| Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer -*Type* ________ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cholesterol - High | ☐ | ☐ | ☐ | ☐ | ☐ |
| Chronic Fatigue | ☐ | ☐ | ☐ | ☐ | ☐ |
| Colitis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Convulsions | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Drug Addictions | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eye Condition | ☐ | ☐ | ☐ | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gall Bladder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gastric/Reflux/Ulcer | ☐ | ☐ | ☐ | ☐ | ☐ |
| Glasses/contacts | ☐ | ☐ | ☐ | ☐ | ☐ |
| Headaches | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hemorrhoids | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Self | Siblings | Mom | Dad | GPs |
|---|---|---|---|---|---|
| HIV/AIDS | ☐ | ☐ | ☐ | ☐ | ☐ |
| Immune System - Weak | ☐ | ☐ | ☐ | ☐ | ☐ |
| Irritable Bowel Syndrome | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lung Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lupus | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ | ☐ |
| Multiple Sclerosis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Muscular Dystrophy | ☐ | ☐ | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | ☐ | ☐ | ☐ |
| Scarlet Fever | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ | ☐ | ☐ |
| Shingles | ☐ | ☐ | ☐ | ☐ | ☐ |
| Skin Disorder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sleep Disorder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Varicose Veins | ☐ | ☐ | ☐ | ☐ | ☐ |
| Venereal Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Weight Gain/Loss | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other ________ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other ________ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other ________ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Patterns

*Mark those that apply and amount if applicable.*

| | |
|---|---|
| **Example:** Lift Weights | 3 X wk |
| Bowel movements | ________ |
| Drive a stick shift | ________ |
| Eat out frequently | ________ |
| Enjoy work | ________ |
| Exercise | ________ |
| Healthy relationships | ________ |
| Lift weights | ________ |
| Nicotine | ________ |
| Phone work excessive | ________ |
| Skip meals | ________ |
| Sleep comfortably | ________ |
| Sleep on stomach | ________ |
| Two story residence | ________ |
| Wear seat belts | ________ |
| Work hours per week | ________ |

## Rate Your Activities

*Rate the degree of pain related to performing these activities.*

| | None | Some | Always |
|---|---|---|---|
| Climbing Stairs | ☐ | ☐ | ☐ |
| Computer work | ☐ | ☐ | ☐ |
| Dressing | ☐ | ☐ | ☐ |
| Driving/riding in cars | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ |
| Getting in/out of cars | ☐ | ☐ | ☐ |
| Getting out of bed | ☐ | ☐ | ☐ |
| Using the restroom | ☐ | ☐ | ☐ |
| Housework | ☐ | ☐ | ☐ |
| Running | ☐ | ☐ | ☐ |
| Sexual Intercourse | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ |
| Taking care of child | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ |
| Yard work | ☐ | ☐ | ☐ |

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# Your Life A5

**Name:** ______________________ **Current Date:** ______________ **Reassess Date:** ______________

***What is your story?** Take time to reflect on your life events from birth to the present time. What have your life events been? Start with birth moving through the life stages. Some examples are a difficult birth, accidents, marriage, divorce, deaths, starting a business, job changes, and financial issues.*

**BIRTH TO 15 YEARS:** ______________________________

**15 TO 30 YEARS:** ______________________________

**30 TO 40 YEARS:** ______________________________

**40 TO 50 YEARS:** ______________________________

**50+ YEARS:** ______________________________

## MY HYDRATION

*What is your average daily intake? (oz.)*

| | |
|---|---|
| Water______________ | Alcohol______________ |
| Caffeine______________ | Soft Drinks______________ |
| Juice______________ | Energy Drinks______________ |
| Milk______________ | Other *(write in)*______________ |

## MY NUMBERS

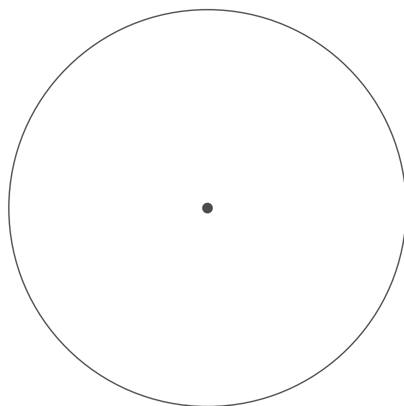
*Please fill in the following...*

| | |
|---|---|
| Blood Pressure______________ | Vitamin D Level______________ |
| Blood Sugar______________ | Height______________ |
| Blood Type______________ | Weight______________ |
| Cholesterol______________ | Other *(write in)* ______________ |

## MY FUEL

*Think about how you eat in a typical week. Indicate what percent you eat of each of the following. (feel free to print this out and graph the chart)*

- Processed Foods
  %______________
- Dairy
  %______________
- Animal Protein
  %______________
- Grains
  %______________
- Fruits
  %______________
- Vegetables
  %______________
- Good Fats
  %______________



## MY WELLNESS PRACTICES

*In the past 3 years, have you had...*

- ☐ Blood analysis / lab work
- ☐ Blood pressure check
- ☐ Bone density scan
- ☐ Cardiovascular stress test
- ☐ Flexible sigmoidoscopy
- ☐ Hearing test
- ☐ Mammogram
- ☐ Pap/pelvic exam
- ☐ Prostate exam
- ☐ Spinal exam
- ☐ Dental exam

## MY MEDICAL PRACTICES

*Mark the wellness disciplines you use.*

- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Dental Care
- ☐ Exercise / Movement Classes
- ☐ Eye Care
- ☐ General Medical
- ☐ Massage Therapy
- ☐ Meditation / Prayer
- ☐ Nutritional Counseling
- ☐ Psychological Counseling
- ☐ Yoga

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# Informed Consent & Financial Policy

A6

**Name:** ______________________ **Date of Birth:** ______________ **Date:** ______________

**Introduction:** Please take a few minutes to carefully read the following and sign where indicated. If you have any questions about the information listed below, please ask the acupuncturist prior to signing this consent.

**Guidelines:** Please use the restroom prior to treatment. Avoid treatment when excessively fatigued, hungry, full, emotionally upset, if you have had alcohol, or shortly after sex. Focus on relaxing throughout the treatment. The more relaxed you are, the better your results will be. Some clients find it helpful to use deep breathing techniques. Do not change your position or move suddenly. If you are uncomfortable during your treatment, please call for your acupuncturist.

**Risks:** As with any medical procedure, there are risks involved. Your acupuncturist will take every precaution during the treatment to minimize any risks. Listed below is the information that is most important for you to understand prior to beginning your acupuncture treatment.

**Needles:** Your acupuncturist uses sterilized, individually packaged, disposable needles that are used once and then discarded. This eliminates the possibility of transmitting a communicable disease by a contaminated needle. The needles are typically inserted anywhere from ¼ to1 inch in depth, depending upon the client's size, age and constitution.

**Bruising:** You may note a spot of blood at one or more of the needle sites or a small bruise could develop. These are rarely harmful, but please talk to your acupuncturist if you are concerned.

**Cupping:** If cupping if used as a treatment, your acupuncturist will use different sized glass jars that are heated with a flame to attach to your back. Depending on one's physical condition, cupping can cause bruising, red marks and in some rare cases, blistering. All of these conditions will disappear without special treatment.

**Herbals:** Herbal medicine may be prescribed as a compliment to your acupuncture treatments and should be taken according to directions provided by the acupuncturist.

**Symptoms:** Symptoms Occasionally, a few people experience dizziness, nausea, cold sweats, and shortness of breath or lightheadedness during treatment. This often occurs if you are nervous. You should inform your practitioner immediately if you experience any discomfort, increased pain, or burning sensations.

**Pain:** If you find your treatment unbearable at any point, be sure to speak up so that your acupuncturist can make the proper adjustments or stop the treatment.

**Treatment:** Your acupuncturist will explain the nature of your problem and what treatment he or she is recommending. If you consent to go ahead with the recommended treatment, your acupuncturist will tell you what progress to expect, what to do if you do not experience that progress and what to do in the rare event that you feel worse.

**Referrals:** If you have been referred for acupuncture by one of our Doctors, your case will continue to be managed by your Doctor. Your Doctor, through consultations with your acupuncturist, will monitor your treatment plan.

**Disclosure:** I have read the above information and fully understand the risks involved in such treatment. I have been given the opportunity to ask any questions. All of my concerns have been addressed to my satisfaction. **I agree to fully disclose any symptoms and health problems of which I am aware throughout the treatment process and will update the acupuncturist immediately should my health status change in any manner.**

## ACUPUNTURE FINANCIAL POLICY

**All payments are due at time of service.** The goal of this office is to provide you with the finest quality care available.
If you have any questions with regard to your healthcare or any of our policies, please let us know.

**Signature:** ______________________________ **Today's Date:** _____ / _____ / _____

**Printed Name:** ______________________________

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