



Thank you for including us in your health care decisions. The following forms help us gather important information so we can begin your care right away. All provided information is strictly confidential.

Patient Information	Contact Information
Today's Date: _____ / _____ / _____ Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Date of Birth: ____ / ____ / ____ Age: _____ Occupation: _____ Employer: _____	Preferred Phone: _____ <i>May we leave a message at the number above? Y/N</i> Email: _____ <i>We will never spam, sell, or distribute your email.</i> Emergency Contact: _____ Phone: _____ Relation: _____ How did you find us? Please help us reach others! _____

Focus of Visit
What is your primary reason for your visit? _____ What was the cause of this condition? _____ When did it start? _____ What makes it better? _____ What makes it worse? _____ What other therapies have you tried to heal your condition? _____ Do you have radiating pain (i.e. down the arm, leg)? _____ If you have pain, please rate your pain on a scale from 1-10 (where 1 is mild and 10 is extreme). _____

Privacy Policy
I have reviewed the privacy policy/HIPPA guidelines for this practice . I understand that my personal information is protected and will not be shared without my written consent for any reason. Signature: _____ Date: _____

Insurance Information

This information can be obtained by calling the number on the back of your insurance card.

Company: _____ Ins. Phone #: _____

Member/Policy ID #: _____ Group# _____ Plan Name: _____

Acupuncture Coverage

Co-Ins/Co-Pay: _____

Deductible: In Net: _____ of _____ // Out of Net: _____ of _____

Visit/Benefit Limits: _____

Insurance Disclaimer:

Every effort will be made by our office to obtain an accurate description of your insurance benefits and file claims on your behalf. **In the event a carrier denies payment the patient is still responsible for the full, remaining balance of their care.**

Signature _____ Date: _____

Medical History

Do you have environmental allergies? Y/N To what: _____ Low/Med/High/Extreme

Do you have food allergies? Y/N To what: _____ Low/Med/High/Extreme

What medication do you take? (**Purpose?**)

What supplements do you take? (**Purpose?**)

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

4. _____

4. _____

Do you notice any negative side effects from your prescribed medication or supplements? Y/N

List side effects _____

Please list all surgeries & dates: _____

TCM Medical History

Have you ever received any of the following TCM therapies:

Acupuncture: Y/N **Herbal Medicine:** Y/N **Cupping:** Y/N **TuiNa:** Y/N **QiGong:** Y/N

If yes, when? (Approx dates): _____ By whom/where? _____

Medical Signs/Symptoms

- | | | | | |
|--|--|---|--|---|
| <input type="radio"/> Abdominal pain | <input type="radio"/> Dark stools | <input type="radio"/> Heart palpitations | <input type="radio"/> Muscle cramps/pain | <input type="radio"/> Short temper |
| <input type="radio"/> Abuse survivor | <input type="radio"/> Decreased libido | <input type="radio"/> Hiccough | <input type="radio"/> Nasal congestion | <input type="radio"/> Shortness of breath |
| <input type="radio"/> Acid reflux | <input type="radio"/> Depression | <input type="radio"/> High blood-pressure | <input type="radio"/> Neck/shoulder pain | <input type="radio"/> Sinus pressure |
| <input type="radio"/> Acne | <input type="radio"/> Dizziness/vertigo | <input type="radio"/> Impotence | <input type="radio"/> Night sweats | <input type="radio"/> Skin infection |
| <input type="radio"/> Asthma | <input type="radio"/> Dry mouth/throat | <input type="radio"/> Increased libido | <input type="radio"/> Nocturnal emission | <input type="radio"/> Smells/body odor |
| <input type="radio"/> Bad breath | <input type="radio"/> Diarrhea | <input type="radio"/> Indigestion | <input type="radio"/> Nosebleeds | <input type="radio"/> Spots in eyes |
| <input type="radio"/> Blood in stools | <input type="radio"/> Ear aches | <input type="radio"/> Intestinal pain | <input type="radio"/> Numbness | <input type="radio"/> Sweat easily |
| <input type="radio"/> Blood in urine | <input type="radio"/> Enlarged thyroid | <input type="radio"/> Irritable | <input type="radio"/> Odorous stools | <input type="radio"/> Sore throat |
| <input type="radio"/> Blurry vision | <input type="radio"/> Eye pain/strain | <input type="radio"/> Itchy eyes | <input type="radio"/> Painful urination | <input type="radio"/> Sudden energy drop |
| <input type="radio"/> Breast lump/pain | <input type="radio"/> Excess phlegm | <input type="radio"/> Itchy skin | <input type="radio"/> Peculiar tastes | <input type="radio"/> Swollen glands |
| <input type="radio"/> Bruise easily | <i>Color:_____</i> | <input type="radio"/> Joint pain | <input type="radio"/> Poor appetite | <input type="radio"/> Teeth/gum problems |
| <input type="radio"/> Chest pains | <input type="radio"/> Excessive saliva | <input type="radio"/> Kidney stones | <input type="radio"/> Poor circulation | <input type="radio"/> Upper back pain |
| <input type="radio"/> Chills | <input type="radio"/> Fatigue | <input type="radio"/> Laxative use | <input type="radio"/> Poor memory | <input type="radio"/> Urgent urination |
| <input type="radio"/> Cold hands/feet | <input type="radio"/> Fever | <input type="radio"/> Limtd range of motion | <input type="radio"/> Poor sleep | <input type="radio"/> Vomiting |
| <input type="radio"/> Concussion | <input type="radio"/> Frequent urination | <input type="radio"/> Loss of hair | <input type="radio"/> Psoriasis | <input type="radio"/> Wake to urinate |
| <input type="radio"/> Cancer:_____ | <input type="radio"/> Gas/bloating | <input type="radio"/> Low back pain | <input type="radio"/> Rash | <input type="radio"/> Weight loss |
| <input type="radio"/> Constipation | <input type="radio"/> Grinding teeth | <input type="radio"/> Migraines | <input type="radio"/> Red eyes | <input type="radio"/> Weight gain |
| <input type="radio"/> Cough | <input type="radio"/> Headache | <input type="radio"/> Mouth sores/ulcers | <input type="radio"/> Seizures | <input type="radio"/> Wheezing |
| <input type="radio"/> Coughing blood | <input type="radio"/> Hemorrhoids | <input type="radio"/> Mucus in stool | <input type="radio"/> Therapy/counseling | |

Women's Health

Date of last menstruation: _____ Is your cycle regular? Y/N Days between periods: _____

Is your period painful? Y/N PMS Cramps Mood swing Emotional STDs _____

How long does your period last? _____ days; Clotting? Y/N If yes, approx. size _____mm

Birth control? Y/N Type/Brand: _____ How long? _____

Men's Health

Are you experiencing any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Difficulty start/stop urination | <input type="checkbox"/> Testicular pain/swelling | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Discharge/sores | <input type="checkbox"/> Erectile difficulty |
| | <input type="checkbox"/> Painful urination | <input type="checkbox"/> STDs _____ |

Other: _____

Pain (If applicable)

Please indicate the areas of pain/tightness/discomfort on the chart.

Pain intensity levels:

None Moderate Severe Terrible

Frequency of Pain?

25% of time 50% 75% Constant

How much work can you perform?

Usual work 25% 50% 75% No work

Does this pain affect your sleep?

No Mildly Greatly Cannot Sleep

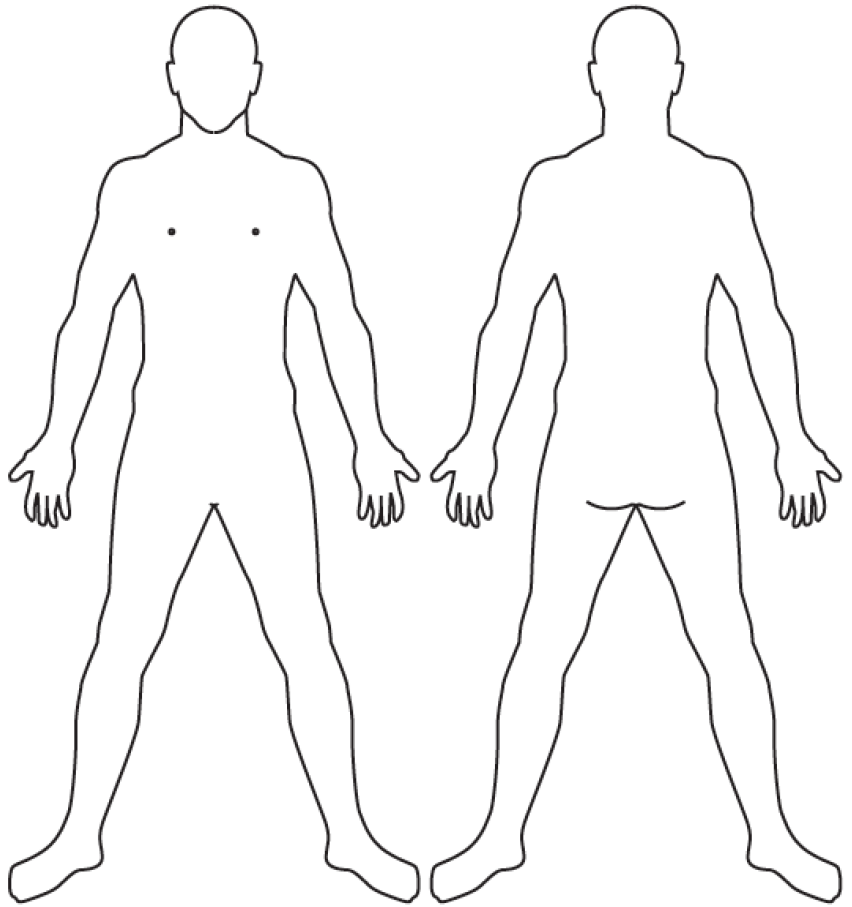
Please describe how the pain feels.
(Sharp/dull/achy/hollow etc.)

When did you first experience this pain?

How has the pain changed since that time?

FRONT

BACK



Practitioner notes: _____

Sun Wellness – Holistic Healthcare

Informed Consent to Treat

I hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture and traditional Asian medicine. Methods of treatment may include, but are not limited to, acupuncture, massage, moxibustion, cupping, electrical stimulation, gua sha, herbal therapy, and nutritional consultations.

I am hereby informed that the aforementioned treatment methods are all generally safe but, as with any medically related treatment or procedure, there may be some side effects or risks, but not limited to, the following:

- ♦ Acupuncture may cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection. Potential risks of moxibustion include blistering, burns, and scarring. Common side effect of cupping and gua sha are temporary bruising and redness lasting up to 10 days.
- ♦ The herbal and nutritional supplements recommended to me are generally safe in the traditionally recommended doses. Examples of possible side effects of herbal and nutritional supplements include nausea, gas, stomach ache, diarrhea, and headache. Examples of unusual side effects of herbs include vomiting, rashes or hives. I understand I must stop taking any herbal and nutritional supplements and notify my acupuncturist if I experience any discomfort or adverse reaction.
- ♦ I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.
- ♦ I understand that I can discuss risks and benefits further before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on my practitioner to exercise their judgment in my best interest during the course of treatment based upon the facts then known.
- ♦ I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.
- ♦ I understand that my practitioner will keep all of my records confidential.

The Georgia Code 360-6-16 states that an acupuncturist is not allowed to make a medical diagnosis of a person's disease. If you are seeking to obtain a medical diagnosis, then you should seek a licensed physician and obtain medical advice from a licensed physician.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment; healthcare operations received, incurred or carried out by my practitioner.

Printed Name of Patient or Responsible Party

Current Date

Signature of Patient or Responsible Party



PLEASE READ THIS IMPORTANT INFORMATION

Clinic Appointments

We respect the time and the energy you put into managing your health care. We will always do our absolute best to provide attentive treatment in a timely manner after you arrive at the clinic. Please help us offer this to you and other patients by arriving *on time* for your scheduled appointment. Patients who arrive more than 10 minutes late for their appointment may be cancelled or rescheduled and incur a missed appointment fee.

Cancellations

If you need to cancel your appointment we require at least 24 business hours notice.

We reserve the right to charge our **full fee** for appointments cancelled with less than twenty-four hours notice or for “no show” appointments.

If you need to change your appointment please call us directly at (678) 468-2266.

Payment for Services Rendered

Payment is due at the time of service and may be paid in cash, check or debit/credit card.

When applicable, our office will make every effort to collect payment from the insurance company. *Patients filing insurance are responsible for any remaining balance after processing has occurred regardless of the reason(s) provided by the insurance company.*

To help keep costs low we prefer payment via check, cash or debit card.

Patient signature or Responsible Party (required)

Date

Patient's printed name