Patient Name:

NEW PATIENT GENERAL HEALTH INTAKE FORM

Today's Date: ____/____/_____

Name:	**Date of Birth:**	**Age:**	**Gender:**

Height:	**Weight:**	**Occupation:**	**Marital Status:**	**How did you hear about Wind in the Willows Acupuncture?**

Phone Number:	**Email:**

Street Address:	**Apt. #:**	**City, State:**	**Zip Code:**

Have you had Acupuncture before?	**Is there any possibility you could be Pregnant?**	**Do you have a Pacemaker or other internal electronic device?**	**Do you have a Blood Borne Pathogen?**
☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

Main reason(s) for visit:	**When did this start?:**
1._____	**1.**_____
2._____	**2.**_____
3._____	**3.**_____

List any **medications, supplements**, and/or **herbs** you are taking (if you need more space, use the back of this document):	List any **surgeries/major illnesses/accidents** (include date):

List any antibiotic use, especially within the past 10 years:

Patient Name:

TELL ME ABOUT YOUR LIFESTYLE:

Typical Breakfast:	Typical Lunch:	Typical Dinner:

Habits: (Check all that apply)	Are you following any special diet?	List any allergies:
☐ Coffee ☐ Tea ☐ Soda ☐ Alcohol ☐ Tobacco ☐ Drugs ☐ Meditation/Mindfulness	☐ Vegetarian ☐ Vegan ☐ Raw ☐ Paleo ☐ Keto ☐ Intermittent Fasting ☐ Other: _____	

Stress Level: (0= No Stress, 10 = Maximum Stress) _____/10	Exercise/Movement: (Type & Frequency)	Any Bad Habits?:

MEDICAL HISTORY:

☑ Check all that apply **PRESENTLY** (medically diagnosed)
O Circle any you have been **PREVIOUSLY** diagnosed with, but may no longer apply

☐ Asthma	☐ Gallstones	☐ Mumps
☐ Anemia	☐ Goiter	☐ Paralysis
☐ Appendicitis	☐ Hepatitis C	☐ Pneumonia
☐ Arteriosclerosis	☐ Hepatitis B	☐ Physical Abuse
☐ Bronchitis	☐ HIV	☐ Polio
☐ Bird Flu	☐ Heart Disease	☐ PTSD
☐ Colitis	☐ Herpes Simplex (Cold Sores/ Genital)	☐ Reynaud's Disease/Syndrome
☐ COPD		☐ Restless Leg Syndrome (RLS)
☐ Chronic Fatigue	☐ Hypertension	☐ Rheumatic Fever
☐ Depression	☐ High Cholesterol	☐ Stroke
☐ Diabetes Type 1/Type 2	☐ Hyper Thyroid	☐ Scarlet Fever
☐ Epilepsy/Seizures	☐ Hypo Thyroid	☐ STD's
☐ Emphysema	☐ Kidney Stones	☐ Tuberculosis
☐ Eating Disorder	☐ Low Blood Pressure	☐ Uterine Fibroids
☐ Fibromyalgia	☐ Mental Illness	☐ Ulcers
☐ Gout	☐ Mono Meningitis	☐ Other: _____

Patient Name:

TRADITIONAL CHINESE MEDICINE QUESTIONS (Please check all that apply):

Energy Level: ☐ Low/No Energy ☐ Moderate Energy ☐ High Energy ☐ Restlessness ☐ Fatigue ☐ Energy Drop During Day ☐ Decreased after Meals ☐ Increased after Meals ☐ Decreased by Exercise ☐ Increased by Exercise	**Sleep:** ☐ Fall Asleep @: _____ ☐ Wake Up @: _____ ☐ Total Hours: _____ ☐ Feel Rested in Morning ☐ Difficulty Falling Asleep ☐ Difficulty Staying Asleep ☐ Toss & Turn ☐ Vivid Dreaming/Nightmares ☐ Disrupted by Pain ☐ Leg Cramps/RLS ☐ Sleep Apnea	**Temperature:** ☐ Always Warm/Hot ☐ Always Cold/Chilled ☐ I Avoid Wind ☐ I Dislike Damp ☐ Fever ☐ Chills ☐ I Feel Dry Overall	**Sweat:** ☐ Spontaneous Sweat ☐ Night Sweats ☐ Strong Body Odor ☐ Clammy Hands/Feet ☐ Can't Sweat ☐ Hot Flashes ☐ Cold Sweats
Appetite/Thirst: ☐ No/Poor Appetite ☐ Excess Hunger ☐ Never Thirsty ☐ Always Thirsty ☐ Thirst for Cold/Ice ☐ Thirst for Room Temp. ☐ Thirst for Warm/Hot	**Head, Ears, Eyes, Nose, Throat:** ☐ Allergies ☐ Impaired Vision ☐ Eye Pain/Strain ☐ Floaters ☐ Night Blindness ☐ Redness/Itchy Eyes ☐ Tearing/Dryness ☐ Dark Circles Under Eyes ☐ Impaired Hearing ☐ Ear Ringing ☐ Ear Infections/Aches ☐ Sinus Problems ☐ Nose Bleeds ☐ TMJ/ Teeth Grinding ☐ Sore Throat ☐ Hoarse Voice ☐ Weak Voice/Laryngitis ☐ Phlegmy ☐ Vertigo ☐ Dry Mouth ☐ Facial Pain	**Digestion:** ☐ Constipation ☐ Diarrhea ☐ Nausea/Vomiting ☐ GERD/Acid Reflux ☐ IBS ☐ Heartburn ☐ Belching ☐ Stomach Ulcers ☐ Diverticulitis/osis ☐ Bad Breath ☐ Bloating ☐ Gas ☐ Hemorrhoids ☐ Abdominal Pain/ Cramping	**Stool/Urine:** ☐ Dry Stool ☐ Sticky Stool ☐ Loose Stool ☐ Watery Stool ☐ Pebble/Marble-like Stool ☐ Snakey Stool ☐ Foul-Odor Stool ☐ Blood in Stool ☐ Urine Incontinence ☐ Dribbling Urine ☐ Difficulty Stopping/ Starting Urination ☐ Painful Urination ☐ Dark/Odorous Urine ☐ Input = Output ☐ Frequently Wake to Urinate ☐ Blood in Urine
Emotions: ☐ Mild Depression ☐ Clinical Depression ☐ ADD/ADHD ☐ Mood Swings ☐ Panic Attacks ☐ PTSD ☐ Anxiety ☐ Overthinking ☐ Trauma/Abuse ☐ Other:_____	**Headaches:** ☐ Headaches ☐ Migraines ☐ Tension ☐ Cluster ☐ Menstrual ☐ Emotional	**Sexual Health:** ☐ Low/No Libido ☐ Excess/High Libido ☐ Normal Libido ☐ Fatigue or Headache After Sexual Activity ☐ Painful Sex ☐ Impotence	**Other:** ☐ Alzheimer's ☐ Dementia ☐ Schizophrenia ☐ Parkinson's ☐ Dizziness/Fainting Spells ☐ Neuropathy ☐ Bell's Palsy ☐ Trigeminal Neuralgia ☐ Shortness of Breath ☐ Frequent Colds ☐ Easy Bruising

Patient Name:

FEMALE HEALTH INTAKE (if Applicable):

MENSTRUATION:

Age of 1st Menses:	Did you have any problems at onset of Menses?: ☐ Yes _____ ☐ No	Date of Last TWO Menstrual Cycles: ____/____/____ ____/____/____
Are your periods regular? ☐ Yes ☐ No	# of Days Bleeding:	# of Days from Onset to Onset:

How Heavy is the Bleeding?	Spotting/Bleeding Between Periods?:	Color of Blood:	Clotting?:	PMS?:
☐ Light ☐ Medium (Tampon/Pad change every ~4 hours) ☐ Heavy	☐ Yes ☐ No	☐ Light Red ☐ Red ☐ Dark Red ☐ Purple ☐ Brown/Black	☐ Yes ☐ No	☐ Yes ☐ No

Please Check All That Apply to Your Cycle:

☐ Irritability ☐ Low Back Pain ☐ Constipation ☐ Diarrhea ☐ Cramping ☐ Water Retention ☐ Anxiety ☐ Depression	☐ Cravings _____ ☐ Acne ☐ Breast Tenderness ☐ Breast Discharge ☐ Hot Flashes ☐ Visual Disturbance ☐ Headache/Migraine ☐ Fatigue	☐ Increased Facial/Body Hair ☐ Excessive Hair Loss (Head) ☐ Vomiting/Nausea ☐ Weight Increase >10 lbs ☐ Weight Decrease > 10lbs ☐ Extraordinary Stress ☐ Fluctuating Emotions	**Sexual Energy/Libido:** ☐ Low ☐ Normal/Average ☐ High ☐ Vaginal Lubricants Used

GYNECOLOGICAL HISTORY (please fill in the blank and CHECK all that apply):

Tell me your # of:			
✖ Pregnancies: _____ ✖ Live Births: _____ ✖ Miscarriages: _____ ✖ Still Borns: _____ ✖ D&Cs: _____	☐ Abnormal Pap smear ☐ Douche Regularly ☐ STDs:_____ ☐ Frequent Yeast Infections ☐ Frequent UTIs ☐ Chronic Vaginal Discharge ☐ Genital Sores ☐ Postpartum Depression	☐ Pelvic Inflammatory Disease ☐ Cervical/Vaginal Operation ☐ Cervical Biopsy ☐ Cauterization/Conization ☐ Freezing (Cryo) ☐ Uterine Fibroids/Polyps	☐ Infertility ☐ Endometriosis ☐ Pelvic Adhesions ☐ Pelvic Abnormalities ☐ PCOS ☐ LUFTS ☐ Menopause (Peri/Post) ☐ Other: _____

Patient Name:

Office Policies & Procedures for Patients

New Patient Appointments

? Please allow approximately 1 1⁄2 - 2 hours for this appointment. During your first visit we will be conducting a comprehensive review of your health and medical history.

? Please arrive at least 15 minutes prior to your appointment time to complete the registration process. This will enable you to get your full scheduled time with the Acupuncturist.

? Be sure you have eaten prior to your visit, but do not eat a large meal.

? Drink water and stay well hydrated

? Wear loose, comfortable clothes

? Refrain from overexertion, drugs or alcohol for at least six hours after treatment

Missed Appointments

? All appointments are considered confirmed at the time they are made.

? Because of the length of time we have reserved for you, please call the office at least 24 hours in advance to reschedule or cancel an appointment. Our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your practitioner's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

Late Arrivals

? If you arrive more than 10 minutes after your scheduled appointment time, it may be necessary to reschedule. However, the missed appointment fee will still apply.

? If you choose to keep your appointment, your visit time will be shortened accordingly.

? Please call if you are running late.

Supplement, Herb, and Homeopathic Return Policy

? We sincerely hope you get the desired effects from the supplements you purchase. However, no one can guarantee that this will happen. Each person is unique in their response. One person may notice great benefit from a supplement, while another may have a side effect or an allergy.

? Combining certain supplements together and/or combining certain supplements with prescription medicines can sometimes lead to unexpected reactions. We cannot guarantee a supplement will help you; however, the products we are offering are of the highest quality available.

? There are no refunds on any supplements or homeopathic remedies.

Medical Records Release

? A signed release is required before any information in your chart can be mailed/faxed to you, another physician or third party.

? The cost of handling copying of your medical records for yourself will be a minimum of $10.

? Records are sent to your physician at no charge.

? If you are having records sent to our office, please have them mailed to our office. Faxed copies are difficult to read.

Payment Policy

? Payments are due in full at the times of service.

? No refunds are issued for any packages. All packages are final sale.

Emergencies

? We do not practice emergency medicine. If you have an emergency, please call 911 or report to your local emergency room.

Patient Name:

FINANCIAL POLICY

Initial Treatments: $145 (75-90 minutes), includes consultation and full treatment.

Follow-up Treatments: $90 (45-60 minutes), includes treatment and lifestyle recommendations.

Credit Card Authorization: A credit card is required for your file.

Payment is expected in full at the time of service.
Accepted forms of payment includes: Cash, check, credit/debit cards, and gift certificates for this clinic. If a check or card is denied or invalid, your credit card on file will be charged for the amount owed, including any returned check fees.

Late Cancellations and No-Shows: I understand that circumstances may arise that prevent patients from keeping an appointment. If you need to reschedule or cancel, please provide us with at least **24 hours** notice by **calling 412-458-1226.**. Please leave a voicemail if I am unable to reach my phone.

With advanced notice, I can contact patients that are on the waiting list. **No-show or late cancellations will be charged the full cost if this happens with an initial visit, and $50 will be charged if this happens with a follow up visit, and the full $90 will be charged for all future late or day of cancellations.**

I have read the Financial Policy above and understand the information.

I hereby authorize Wind in the Willows Acupuncture LLC to charge my credit card on file for services rendered or according to the late cancellation and no-show policy above. I understand that my information will be saved to file for future transactions on my account.

Print Name: _____

Signature: _____ **Date**: _____

Patient Name:

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on myself (or on the patient named below, for whom I am legally responsible) by the acupuncturist employed at Wind in the Willows Acupuncture LLC. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that methods of treatment may include, but are not limited to: acupuncture, cupping, gua sha (scraping), moxibustion, electrical stimulation, Tui Na (Chinese massage), Chinese herbal medicine, hot packs, heat lamps, blood-letting, non-needle techniques, aromatherapy, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including bruising, numbness or tingling near the needling sites that may last a few days, as well as dizziness and fainting. Extremely rare risks of acupuncture include nerve damage and organ puncture (including lung puncture – pneumothorax). Infection is another possible risk, though the clinic uses sterile, single-use, disposable needles and maintains a clean and safe environment while following Clean Needle Technique standards.

Burns, blisters, and/or scarring are potential risks of moxibustion or cupping, or when the treatment involves the use of heat. Practitioners are highly trained to avoid and minimize these risks.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that it is my responsibility to follow the instructions provided. I will notify my practitioner of any unanticipated or unpleasant effects associated with the consumption of the herbs. I understand that some herbs may be inappropriate during pregnancy or lactation. Some possible herbal side effects are: nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify my practitioner if any of these side effects occur, or if I am pregnant (or nursing) or become pregnant.

While I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the practitioner to exercise judgement during the course of treatment, based on known facts, and make decisions in my best interest. I understand that results are not guaranteed.

I understand that the practitioner may review my patient records and lab reports, but all of my records will be kept confidential and will not be released without my written consent. I am aware of the **financial policy** and **HIPAA practices** adhering to this clinic and know I can request a copy at any time.

By voluntarily signing below, I show that I have read, or have had read to me the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Name:

Signature: _____ **Date**: _____

HIPAA NOTICE OF PRIVACY PRACTICES & HIPAA ACKNOWLEDGEMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
The Notice refers to Michelle Wheeler, L.Ac. by using the terms "us," "we," or "our."

Michelle Wheeler, L.Ac. keeps electronic health records (EHR) and applies reasonable safeguards to protect your Personal Health Information and privacy and has implemented the minimum necessary standard concerning sharing your Personal Health Information. The minimum required standard limits how much protected health information is used, disclosed, and requested for specific purposes, and also reasonably limit who within the clinic has access to protected health information, and under what conditions, based on job responsibilities and the nature of the business.

We are required by law to maintain the privacy of Personal Health Information. We are required to provide this Notice of Privacy Practices to you by the privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH").

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be valid for all Personal Health Information that we maintain at that time. This notice may also be revised if there is a material change to the uses or disclosures of Personal Health Information, your rights, our legal duties, or other privacy practices stated in this notice.

Within 60 days of a material revision to this notice, we will make available a copy of the revised notice at your place of treatment. Additionally, we will provide you with any revised Notice of Privacy Practices if you request that a revised copy be provided to you.

How We May Use and Disclose Personal Health Information About You

The common reasons for which we may use and disclose your Personal Health Information are to process and review your requests for coverage and payments for benefits or in connection with other health-related benefits or services in which you may be interested. The following describes these and other uses and disclosures and includes some examples.

For Treatment: We will use and disclose your Personal Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. We will also disclose Personal Health Information to other physicians who may be treating you. Also, we may disclose your Personal Health Information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by assisting with your health care diagnosis or treatment to your physician. Additionally, we may disclose your Personal Health Information to others who may help in your care, such as your physician, therapists, or medical equipment suppliers.

For Payment: We may use or disclose information for billing, claims management, collection activities, and obtaining payment under a contract for reinsurance and related healthcare data processing. Also, we may use your Personal Health Information to bill you directly for services and items.

For Appointment Reminders: We may contact you to remind you about your appointment for services.

For Health-Related Benefits and Services: We may use and disclose Personal Health Information to tell you about health-related benefits and services that may be of interest to you.

As Required By Law: We will share your medical information when required to do so by federal, state, or local law.