

Angie's Acupuncture

Holistic Lifestyle & Nutrition

10339 Chapman Highway

Seymour, TN, 37865

865-250-7737

www.angiesacupuncture.com

Name: _____ Age: _____ Sex: _____ Phone#: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____ Marital Status: _____

Emergency Contact: _____ Emergency Contact Phone #: _____

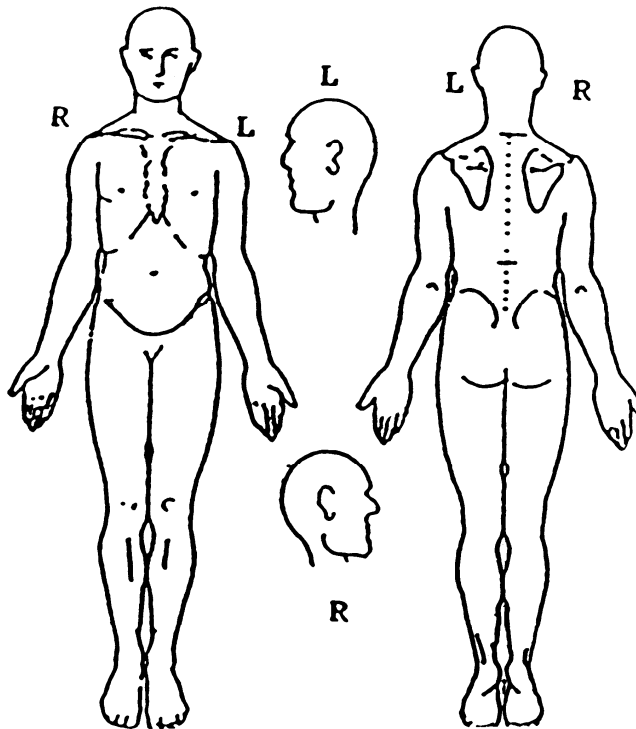
Party Responsible for Payment: _____ Relationship to You: _____

Email Address: _____ How did you Hear about us: _____

List Top 2 Main Complaints: **For How Long?** **Impairs Daily Activities?** **Health Professional Seen?**

1. _____

2. _____



PLEASE MARK OR COLOR IN ALL AREAS OF PAIN OR DISCOMFORT, ON THE DIAGRAM ABOVE.

Pain is: (check all that apply): Sharp [] Burning [] Moving [] Fixed [] Dull [] Aching [] Stabbing []

Radiates to: _____

Please Check if you Ever have had any of the Following.			
<input type="checkbox"/>	AIDS	<input type="checkbox"/>	Hives
<input type="checkbox"/>	Positive test for AIDS/HIV Antibodies	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	Kidney or Bladder Infection
<input type="checkbox"/>	Bone Disease	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Low / High Blood Pressure
<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Cancer or Tumor	<input type="checkbox"/>	Malaria
<input type="checkbox"/>	Colon/Bowel Disease	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Pleurisy
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Polio
<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	Prostatitis
<input type="checkbox"/>	Drug Habit	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Drug Sensitivity or Reaction	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Emotional or Mental Problems	<input type="checkbox"/>	Small Pox
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Spinal Meningitis
<input type="checkbox"/>	Gall Stones	<input type="checkbox"/>	Stomach or Duodenal Ulcer
<input type="checkbox"/>	Gall Bladder Problems	<input type="checkbox"/>	Tendonitis
<input type="checkbox"/>	German Measles	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	Thyroid or Goiter Trouble
<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Whooping Cough

(Circle 1 for the Least Severe, and 5 for the Most Severe.)

Current	Symptom	1=least Severe 5=most Severe	Current	Symptom	1=Least Severe 5=Most Severe
<input type="checkbox"/>	Abdominal/Stomach Pain	1 2 3 4 5	<input type="checkbox"/>	Frequent or Extended Hoarseness	1 2 3 4 5
<input type="checkbox"/>	Always Hungry	1 2 3 4 5	<input type="checkbox"/>	Hearing Difficulties	1 2 3 4 5
<input type="checkbox"/>	Black Stools	1 2 3 4 5	<input type="checkbox"/>	Nose Bleeds	1 2 3 4 5
<input type="checkbox"/>	Constipation	1 2 3 4 5	<input type="checkbox"/>	Sinus Problems	1 2 3 4 5
<input type="checkbox"/>	Diarrhea	1 2 3 4 5	<input type="checkbox"/>	Sore Throats	1 2 3 4 5
<input type="checkbox"/>	Heartburn	1 2 3 4 5	<input type="checkbox"/>	Sounds/Ringing in Ears	1 2 3 4 5
<input type="checkbox"/>	Indigestion	1 2 3 4 5	<input type="checkbox"/>	Swollen Glands	1 2 3 4 5
<input type="checkbox"/>	Gas	1 2 3 4 5	<input type="checkbox"/>	Trouble with your Eyes	1 2 3 4 5
<input type="checkbox"/>	Lack of Appetite	1 2 3 4 5	<input type="checkbox"/>	Unusual Taste in Mouth	1 2 3 4 5
<input type="checkbox"/>	Nausea	1 2 3 4 5	<input type="checkbox"/>	Dry Skin	1 2 3 4 5
<input type="checkbox"/>	Overweight	1 2 3 4 5	<input type="checkbox"/>	Itching or Burning Skin	1 2 3 4 5
<input type="checkbox"/>	Unusually Thirsty	1 2 3 4 5	<input type="checkbox"/>	Skin Rash	1 2 3 4 5
<input type="checkbox"/>	Vomiting	1 2 3 4 5	<input type="checkbox"/>	Bloody Urination	1 2 3 4 5
<input type="checkbox"/>	Weight Changes	1 2 3 4 5	<input type="checkbox"/>	Burning Urination	1 2 3 4 5
<input type="checkbox"/>	Bleeding Easily	1 2 3 4 5	<input type="checkbox"/>	Difficult Urination	1 2 3 4 5
<input type="checkbox"/>	Bleeding Gums	1 2 3 4 5	<input type="checkbox"/>	Frequent Urination	1 2 3 4 5
<input type="checkbox"/>	Bruising Easily	1 2 3 4 5	<input type="checkbox"/>	Loss of Bladder Control	1 2 3 4 5
<input type="checkbox"/>	Chest Pain or Pressure	1 2 3 4 5	<input type="checkbox"/>	Painful Urination	1 2 3 4 5
<input type="checkbox"/>	Dizzy Spells	1 2 3 4 5	<input type="checkbox"/>	Urination at Night	1 2 3 4 5
<input type="checkbox"/>	Irregular Heart Beat	1 2 3 4 5	<input type="checkbox"/>	Sexual Concerns	1 2 3 4 5
<input type="checkbox"/>	Poor Circulation	1 2 3 4 5	<input type="checkbox"/>	Convulsions	1 2 3 4 5
<input type="checkbox"/>	Pounding Heart Beat	1 2 3 4 5	<input type="checkbox"/>	Depression	1 2 3 4 5
<input type="checkbox"/>	Racing Heart Beat	1 2 3 4 5	<input type="checkbox"/>	Fatigue or Tiredness	1 2 3 4 5
<input type="checkbox"/>	Chest Colds	1 2 3 4 5	<input type="checkbox"/>	Frequent or Severe Headache	1 2 3 4 5
<input type="checkbox"/>	Chronic Cough	1 2 3 4 5	<input type="checkbox"/>	Difficulty Getting to Sleep	1 2 3 4 5

<input type="checkbox"/>	Congested Nose	1 2 3 4 5	<input type="checkbox"/>	Difficulty Staying Asleep	1 2 3 4 5
<input type="checkbox"/>	Coughing up Blood	1 2 3 4 5	<input type="checkbox"/>	Leg Cramps	1 2 3 4 5
<input type="checkbox"/>	Smoking	1 2 3 4 5	<input type="checkbox"/>	Nervousness	1 2 3 4 5
<input type="checkbox"/>	Sneezing	1 2 3 4 5	<input type="checkbox"/>	Numbness or Tingling	1 2 3 4 5
<input type="checkbox"/>	Wheezing	1 2 3 4 5	<input type="checkbox"/>	Shaking or Trembling	1 2 3 4 5
<input type="checkbox"/>	Chills	1 2 3 4 5	<input type="checkbox"/>	Stuttering or Stammering	1 2 3 4 5
<input type="checkbox"/>	Excessive Sweating	1 2 3 4 5	<input type="checkbox"/>	Back Trouble	1 2 3 4 5
<input type="checkbox"/>	Fever	1 2 3 4 5	<input type="checkbox"/>	Pain or Swelling-any Joint	1 2 3 4 5
<input type="checkbox"/>	Lack of Perspiration	1 2 3 4 5	<input type="checkbox"/>	Painful Feet	1 2 3 4 5
<input type="checkbox"/>	Night Sweats	1 2 3 4 5	<input type="checkbox"/>	Painful Muscles	1 2 3 4 5
<input type="checkbox"/>	Tendency to be too Cold	1 2 3 4 5	<input type="checkbox"/>	Stiff or Painful Neck	1 2 3 4 5
<input type="checkbox"/>	Tendency to be too Hot	1 2 3 4 5	<input type="checkbox"/>	Swelling of Feet or Legs	1 2 3 4 5
<input type="checkbox"/>	Earaches	1 2 3 4 5	<input type="checkbox"/>	Neuropathy	1 2 3 4 5

Check if you have Family History					
<input type="checkbox"/>	AIDS	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	Problems with Alcohol
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Main Complaint	<input type="checkbox"/>	Cancer

How long have you been trying to conceive? _____

How long have you been taking oral contraceptives? _____ Date stopped? _____

Date of Last Menstrual Cycle: _____

Have you had any tubal operations? _____

Have you had any hormone laboratory test preformed? _____

Have you or your partner had a diagnosis related to infertility? Yes No

If yes, Diagnosis, Doctor's Name and Clinic: _____

Have you or your partner been to a fertility doctor? Yes No

If yes: Doctor's Name and Clinic _____

How is your sexual energy? Low Normal High

Age at which menses began _____

Has your cycle changed since they began? Yes No

How? _____

Does your face break out before or during your period? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Are your periods painful? Yes No

How many days do you normally bleed? _____

How heavy is the bleeding? Light Normal Heavy

What color is the blood? Light red Red Dark red Purple Brown Black

Is there clotting? Yes No

Do you ovulate on your own? Yes No

On what day of your cycle do you ovulate? _____

Do your breasts get tender at/during ovulation? Yes No

Have you ever had an abnormal pap smear Yes No

Do you get yeast infections regularly? Yes No

Have you ever been diagnosed with Chlamydial Infection? Yes No

Do you have chronic vaginal discharge? Yes No

Do you have any sores on your genitalia? Yes No

Have you ever had pelvic inflammatory disease? Yes No

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you taken any medications for gynecological conditions other than contraceptives? Yes No

Medications

Reasons

How Long

List of all Surgeries: _____

List your Typical Daily Meals: _____

List all Current Medicines and/or Supplements/Nutrition: _____

I would Like to be Involved in E-Mails Regarding Angie's Acupuncture & Holistic Lifestyle Living.

Due to Allergies of Angie and Some Patients, We Ask that you Refrain from Wearing Scented Hairspray, Colognes, Scented Lotions, etc.

Payments for Acupuncture Treatments, Supplements, Nutritional Response Testing® and/or Cupping are due when Treatments are Performed, unless Arrangements are made Prior to Treatment by Angela Buckridge, L.A.c.

All the above Information is True, to the Best of my Knowledge.

Patient (or Guardian) Signature: _____ **Date:** _____

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Notice of Patient Privacy **HIPPA**

(Health Insurance Portability and Accountability Act)

Angie's Acupuncture and staff is required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. By law, this is your notice that we are required by law to protect you.

Required by law, we must have written consent before we use or disclose your medical information to others. I authorize Angie's Acupuncture and Holistic Lifestyle Living to secure my protective information and protect my rights. If it is required by law that all treatment notes are submitted to insurance/VA/ auto-accidents plans, and/or health savings plan, I agree to this exchange of information. We are here to assist you to provide or arranging your healthcare, payment for reimbursement of treatment provided and/or related administrative activities supporting your healthcare.

You are provided the right to inspect and receive a copy of your medical information, obtain an accounting or disclosures of your patient file. You may request that we communicate with you confidentially or that we restrict certain uses and disclosures of your health information. Please notify my clinic if you think your rights have been violated.

If you have any questions, or concerns about this NOTICE or your medical information, please contact Angie's Acupuncture at 865-250-7737.

Patient (or Guardian) Signature: _____ **Date:** _____

Angie's Acupuncture

Holistic Lifestyle & Nutrition

Informed Consent for Acupuncture, Cupping, and/or Nutritional Response Testing®: Oriental Medicine

By signing below, I hereby voluntarily consent to be treated with acupuncture, cupping, and/or Nutritional Response Testing® from the Oriental Materia Medica by Angela Buckridge L.A.c and staff. I understand that acupuncturists practicing in the state of Tennessee are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended. I understand all medications that are prescribed by a medical physician **will not be discontinued or reduced until I consult with my physician.**

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on the body in an attempt to treat health concerns. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and/or the possible aggravation of symptoms existing prior to acupuncture treatment. I will report to Angie's Acupuncture and/or staff of any dizziness, light-headedness or discomfort that occurs during or after an acupuncture treatment. I understand that there are no guarantees concerning my symptom(s) and that I am free to stop acupuncture treatment at any time. I understand that sometimes symptoms can get worse before they get better. **I will be educated that all needles are sterile and individually packaged and disposed of properly.**

Cupping: Is a therapy designed to stimulate the flow of blood and Qi within the superficial muscle layers. It is used for many ailments including sore muscles, tension, neck pain and the common cold. In this therapy I understand Angie will place small glass "cups" over specific areas on my body. A vacuum is created under the cup with heat or suction. They may be moved over an affected area or left in place. I also understand that I may leave the office looking as though an octopus gave me a big hug. There is no need for alarm. The slight redness will dissipate.

Nutritional Response Testing® and Supplements: I understand that I am not required to take these substances and I have the right to discontinue them at any time. I understand that Nutritional Response Testing® is a response to the sympathetic and autonomic nervous system in the body. I understand that I must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to nutrition/herbal supplements. Should I experience any problems, which I associate with these supplements, I should suspend taking them and call Angie's Acupuncture as soon as possible. **Some nutritional/herbal supplements may be inappropriate during pregnancy and/or breastfeeding. I accept full responsibility to inform Angie's Acupuncture of a suspected or confirmed pregnancy or if I am a nursing mother. Some supplements may be inappropriate when there is a change of medication. I accept full responsibility to inform Angie's Acupuncture upon change of medications or any new information concerning my well being. I agree to report any changes of my health to my primary doctor.**

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand the possible risks and complications are involved. I understand that I may ask Angie's Acupuncture and Holistic Living Lifestyle Living for a more detailed explanation. I give my permission and consent for treatment regarding Angie's Acupuncture and Holistic Lifestyle & Nutrition. I understand that I have the right to refuse or discontinue any treatment at any time, and this refusal or delay in treatment may affect my body's healing process.

Patient (or Guardian) Signature: _____ **Date:** _____

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Financial and Billing Policy

Rates: Acupuncture Treatment (Out of Pocket)

\$90.00 for Initial Consultation and Acupuncture Treatment

\$60.00 for Follow-up Acupuncture Treatments

\$480.00 for 10 Follow-up Acupuncture Treatments

***Saving \$120.00**

\$265.00 for 5 Follow-up Acupuncture Treatments

***Saving \$35.00**

Rates: Cupping with Acupuncture Treatment (Out of Pocket)

\$25.00 for Cupping with the Paid Purchase of an Acupuncture Treatment

\$200.00 for 10 Follow-up Cupping with the Paid Purchase of Acupuncture Treatments

***Saving \$50.00**

\$110.00 for 5 Follow-up Cupping with the Paid Purchase of Acupuncture Treatments

***Saving \$15.00**

Rates: Cupping without Acupuncture Treatment (Out of Pocket)

\$75.00 for Initial Consultation and Cupping

\$45.00 for follow-up Cupping

Rates: Nutritional Response Testing® (Out of Pocket)

\$90.00 for Initial Consultation and Nutritional Response Testing® and HRV Test

\$25.00 for Additional HRV Testing

\$40.00 for Follow-up Nutritional Response Testing®

\$15.00 for Extended Visits, which may be Required from Time to Time

\$360.00 for 12 Follow-up Nutritional Response Testing® for (Includes HRV)

***Saving \$120.00**

\$204.00 for 6 Follow-up Nutritional Response Testing® (Includes HRV)

***Saving \$36.00**

\$15.00 and up for Nutrition, Herbal Supplements and/or Vitamins

Cancellation Policy

I agree to call **no less than 24 hours** before my scheduled appointment if I must cancel or change my appointment date or time. I agree that if it is after hours, I will call and leave a message as soon as possible. Failure to do so may result in being billed the full amount of treatment.

By signing below, I acknowledge that I have read the information on this form and agree to this policy. Due to allergies of Angie and some patients, we ask that you refrain from wearing scented hairspray, colognes, scented lotions & etc.

Patient (or Guardian) Signature: _____ Date: _____