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 #: _______________________________

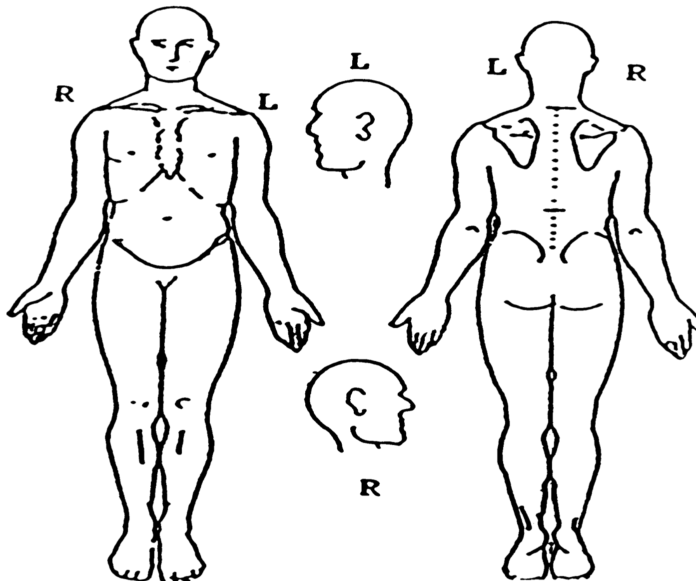
Party Responsible for Payment: _______________________________ Relationship to You: __________________________

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.				
☐	AIDS		☐	Hives
☐	Positive test for AIDS/HIV Antibodies		☐	Kidney Stones
☐	Blood Transfusions		☐	Kidney or Bladder Infection
☐	Bone Disease		☐	Liver Disease
☐	Bronchitis		☐	Low / High Blood Pressure
☐	Bursitis		☐	Lupus
☐	Cancer or Tumor		☐	Malaria
☐	Colon/Bowel Disease		☐	Mononucleosis
☐	Allergies		☐	Mumps
☐	Anemia		☐	Pancreatitis
☐	Arthritis		☐	Pleurisy
☐	Asthma		☐	Pneumonia
☐	Diabetes		☐	Polio
☐	Diphtheria		☐	Prostatitis
☐	Drug Habit		☐	Rheumatic Fever
☐	Drug Sensitivity or Reaction		☐	Scarlet Fever
☐	Emotional or Mental Problems		☐	Small Pox
☐	Emphysema		☐	Spinal Meningitis
☐	Gall Stones		☐	Stomach or Duodenal Ulcer
☐	Gall Bladder Problems		☐	Tendonitis
☐	German Measles		☐	Tuberculosis
☐	Heart Trouble		☐	Thyroid or Goiter Trouble
☐	Hepatitis/Jaundice		☐	Varicose Veins
☐	Herpes		☐	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
☐	Abdominal/Stomach Pain	1 2 3 4 5		☐	Frequent or Extended Hoarseness	1 2 3 4 5
☐	Always Hungry	1 2 3 4 5		☐	Hearing Difficulties	1 2 3 4 5
☐	Black Stools	1 2 3 4 5		☐	Nose Bleeds	1 2 3 4 5
☐	Constipation	1 2 3 4 5		☐	Sinus Problems	1 2 3 4 5
☐	Diarrhea	1 2 3 4 5		☐	Sore Throats	1 2 3 4 5
☐	Heartburn	1 2 3 4 5		☐	Sounds/Ringing in Ears	1 2 3 4 5
☐	Indigestion	1 2 3 4 5		☐	Swollen Glands	1 2 3 4 5
☐	Gas	1 2 3 4 5		☐	Trouble with your Eyes	1 2 3 4 5
☐	Lack of Appetite	1 2 3 4 5		☐	Unusual Taste in Mouth	1 2 3 4 5
☐	Nausea	1 2 3 4 5		☐	Dry Skin	1 2 3 4 5
☐	Overweight	1 2 3 4 5		☐	Itching or Burning Skin	1 2 3 4 5
☐	Unusually Thirsty	1 2 3 4 5		☐	Skin Rash	1 2 3 4 5
☐	Vomiting	1 2 3 4 5		☐	Bloody Urination	1 2 3 4 5
☐	Weight Changes	1 2 3 4 5		☐	Burning Urination	1 2 3 4 5
☐	Bleeding Easily	1 2 3 4 5		☐	Difficult Urination	1 2 3 4 5
☐	Bleeding Gums	1 2 3 4 5		☐	Frequent Urination	1 2 3 4 5
☐	Bruising Easily	1 2 3 4 5		☐	Loss of Bladder Control	1 2 3 4 5
☐	Chest Pain or Pressure	1 2 3 4 5		☐	Painful Urination	1 2 3 4 5
☐	Dizzy Spells	1 2 3 4 5		☐	Urination at Night	1 2 3 4 5
☐	Irregular Heart Beat	1 2 3 4 5		☐	Sexual Concerns	1 2 3 4 5
☐	Poor Circulation	1 2 3 4 5		☐	Convulsions	1 2 3 4 5
☐	Pounding Heart Beat	1 2 3 4 5		☐	Depression	1 2 3 4 5
☐	Racing Heart Beat	1 2 3 4 5		☐	Fatigue or Tiredness	1 2 3 4 5
☐	Chest Colds	1 2 3 4 5		☐	Frequent or Severe Headache	1 2 3 4 5
☐	Chronic Cough	1 2 3 4 5		☐	Difficulty Getting to Sleep	1 2 3 4 5
☐	Congested Nose	1 2 3 4 5		☐	Difficulty Staying Asleep	1 2 3 4 5

☐	Coughing up Blood	1 2 3 4 5		☐	Leg Cramps	1 2 3 4 5
☐	Smoking	1 2 3 4 5		☐	Nervousness	1 2 3 4 5
☐	Sneezing	1 2 3 4 5		☐	Numbness or Tingling	1 2 3 4 5
☐	Wheezing	1 2 3 4 5		☐	Shaking or Trembling	1 2 3 4 5
☐	Chills	1 2 3 4 5		☐	Stuttering or Stammering	1 2 3 4 5
☐	Excessive Sweating	1 2 3 4 5		☐	Back Trouble	1 2 3 4 5
☐	Fever	1 2 3 4 5		☐	Pain or Swelling-any Joint	1 2 3 4 5
☐	Lack of Perspiration	1 2 3 4 5		☐	Painful Feet	1 2 3 4 5
☐	Night Sweats	1 2 3 4 5		☐	Painful Muscles	1 2 3 4 5
☐	Tendency to be too Cold	1 2 3 4 5		☐	Stiff or Painful Neck	1 2 3 4 5
☐	Tendency to be too Hot	1 2 3 4 5		☐	Swelling of Feet or Legs	1 2 3 4 5
☐	Earaches	1 2 3 4 5		☐	Neuropathy	1 2 3 4 5

Check if you have Family History							
☐	AIDS		☐	Diabetes		☐	Mental Illness
☐	Allergies		☐	Infertility		☐	Problems with Alcohol
☐	Anemia		☐	High Blood Pressure		☐	Stroke
☐	Arthritis		☐	Heart Disease		☐	Thyroid Disease
☐	Asthma		☐	Main Complaint		☐	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 bowl 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 <u>Like</u> to be Involved in E-Mails Regarding Angie's Acupuncture & Holistic Lifestyle Living.**

☐ **Due to Allergies that many people suffer from in this area, 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 Phifer, 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:** ______________________

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 Phifer, 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)
$95.00 for Initial Consultation and Acupuncture Treatment
$65.00 for Follow-up Acupuncture Treatments (if seen within the last 24 months)
$530.00 for 10 Follow-up Acupuncture Treatments
***Saving $120.00**
$290.00 for 5 Follow-up Acupuncture Treatments
***Saving $35.00**

Rates: Cupping with Acupuncture Treatment (Out of Pocket)
$30.00 for Cupping with the Paid Purchase of an Acupuncture Treatment
$250.00 for 10 Follow-up Cupping with the Paid Purchase of Acupuncture Treatments
***Saving $50.00**
$135.00 for 5 Follow-up Cupping with the Paid Purchase of Acupuncture Treatments
***Saving $15.00**

Rates: Cupping without Acupuncture Treatment (Out of Pocket)
$80.00 for Initial Consultation and Cupping
$50.00 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 that many people suffer from in this area, we ask that you refrain from wearing scented hairspray, colognes, scented lotions & etc.

Patient (or Guardian) Signature: ____________________________Date: ___________________________