ELIXIR
LIFESTYLE MEDICINE

From pain relief to stress relief and enhancing your wellbeing with acupuncture, Traditional Chinese Medicine, nutritional counseling and bodywork, it is our pleasure to be your partner on your quest for greater health. To simplify your visit and ensure fair and prompt service, please note the following office policies:

* We have a 24-hour cancellation policy. This means you will be charged in full for not keeping your appointment, unless we have notice AT LEAST 24-hours in advance.

* Please be timely. If you are late, it shortens your treatment time. Other patients will not be delayed to accommodate your late arrival.

* If you are more than 20 minutes late, you will have missed your appointment and incur a missed appointment fee.

* If your insurance doesn't cover your treatment, you will be responsible for paying in full. This includes the New Patient Intake on your first appointment & any extra services that are not covered by your insurance. This means that you will personally need to pay for services. No exceptions.

* Once established with your insurance company, your co-pay is due at the time of service. We reserve the right to refuse care to patients who do not meet the co-pay requirement, or whose payments are in arrears.

* As a courtesy we will provide a printed superbill for out of network patients.

* Supplements must be paid in full at the time of pick up. Unopened supplements may be returned within 14 days. There will be a 15% restocking fee.

* Opened supplements and custom herbal formulas are non-refundable.

* We accept cash, checks, and credit cards.

* Outstanding balances over 30 days are subject to a 1.5% fee, and there will be a $25.00 fee on ALL bounced checks.

* If your account has a balance and is not paid within 60 days from the due date, your account will be turned over to collections and your credit will be negatively affected.

* Treatments provided are non-refundable after services are rendered.

Yours in Health, Elixir Lifestyle Medicine

Patient Signature_____ Date_____

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Health History Form

Name: _____ Date: _____

Age: _____ Date of Birth: _____ City of Birth: _____

Sex at Birth: _____Preferred Gender Identity: _____

Address: _____City: _____ State: _____ Zip: _____

Phone #:_____Email Address:_____

Marital Status: _____

Occupation: _____

Person(s) to reach in an emergency: _____

Relationship(s): _____ Phone #'s: _____

May I thank someone for referring you to me? _____

Health History Questionnaire

What are your top THREE most important health problems or goals? Please, list in order of importance.

1.)_____

2.)_____

3.)_____

Do you have a diagnosed illness or disease that we should list as a part of your health history?

General

Weight today _____lbs. Weight one year ago? _____lbs.

Desired Weight _____lbs. Height _____

Who is your primary care physician? _____

Are you currently receiving healthcare for any reason? Yes No

If yes, where and from whom? _____

For what reason(s)? _____

_____

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental things? _____

Do you use tobacco, currently? Y N Smoked previously? Y N

How much, how often? _____
How many years?_____
How many packs per day? _____

Current Medications/ Supplements/Herbs/Homeopathic:

Please list ALL vitamins, herbs, supplements, prescription medication and over the counter medications you are taking, on a regular basis. Please include how often taken and milligram amount.

_____

_____

_____

_____

_____

Y= Yes, P= Past, N= No

Gastrointestinal

Trouble Swallowing?	Y P N	Heartburn/ Reflux?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea/ Vomiting	Y P N	Bowel Movements HOW OFTEN? _____	
Blood in stool?	Y P N	Is this a change? _____	
Pain or cramps (not menstrual)?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Ulcer History?	Y P N	Liver Disease?	Y P N
Gallbladder problems?	Y P N	Hemorrhoids?	Y P N
History of eating disorders?	Y P N		

Eyes

Glaucoma?	Y P N	Cataracts?	Y P N
Impaired Vision?	Y P N	Tearing or dryness?	Y P N
Eye pain/ strain?	Y P N	Glasses or contacts?	Y P N
Visual disturbances?	Y P N		

Neurological

Loss of memory?	Y P N	Vertigo or dizziness?	Y P N
Seizures?	Y P N	Paralysis?	Y P N
Muscle Weakness?	Y P N	Numbness or tingling?	Y P N

Musculoskeletal

Osteopenia/ osteoporosis?	Y P N	Bones density study?	Y P N Date:_____
Joint pain or stiffness?	Y P N	Arthritis?	Y P N
Muscle spasms or cramps?	Y P N	Sciatica?	Y P N

Respiratory

Shortness of breath?	Y P N	Emphysema?	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Tuberculosis history?	Y P N
Cough?	Y P N	Wheezing?	Y P N

Urinary

Increased frequency? Y P N
Pain on urination? Y P N
Kidney Stones? Y P N
Inability to hold urine? Y P N
Frequent infections? Y P N

Mental/ Emotional

Memory Problems? Y P N
Poor concentration? Y P N
Mood swings? Y P N
Anxiety or nervousness? Y P N
Psychological difficulties? Y P N
Tension/ Easily stressed? Y P N
Considered or attempted suicide? Y P N
Depression? Y P N

Neck

Pain or stiffness? Y P N
Swollen glands? Y P N
Goiter? Y P N
Lumps? Y P N

Head

Headaches? Y P N
Migraines? Y P N
Jaw/ TMJ problems? Y P N
Head injury history? Y P N

Mouth and Throat

Hoarseness? Y P N
Frequent sore throat? Y P N
Sore tongue/ lips? Y P N
Dental problems? Y P N
Teeth grinding? Y P N
Gum problems? Y P N

Ears

Earaches? Y P N
Ringing? Y P N
Dizziness? Y P N
Impaired hearing? Y P N

Nose and Sinuses

Sinus problems?	Y P N	Loss of smell?	Y P N
Frequent colds?	Y P N	Nose bleeds?	Y P N
Stuffiness?	Y P N	Hay fever?	Y P N

Skin

Unusual lumps/ lesions/ moles?	Y P N	Night sweats?	Y P N
Rashes, Eczema, or hives?	Y P N	Acne or boils?	Y P N
Itching?	Y P N	Perpetual hair loss?	Y P N

Endocrine

Fatigue?	Y P N	Seasonal depression?	Y P N
Hypo or hyperthyroid?	Y P N	Heat or cold intolerance?	Y P N
Excessive thirst or hunger?	Y P N	Diabetes?	Y P N
Hypoglycemia?	Y P N	Cold hands or feet?	Y P N

Cardiovascular

High blood pressure/ strokes?	Y P N	Swelling in ankles/ feet?	Y P N
Heart disease/ heart attack?	Y P N	Angina/ chest pain?	Y P N
Blood clot history?	Y P N	Palpitations/ Fluttering?	Y P N
High cholesterol?	Y P N	Murmurs/ valve problems?	Y P N

Blood/ Peripheral Vascular

Easy bleeding or bruising?	Y P N	Circulatory problems?	Y P N
Varicose veins?	Y P N	Anemia History?	Y P N

Seasonal Allergies

Itchy eyes?	Y P N	Stuffiness?	Y P N
Loss of smell?	Y P N	Itchy ears?	Y P N
Sneezing?	Y P N	Chronic mucus productions?	Y P N

Female Reproductive System

Age of first menses? _____
Age/ date of last menses? _____
1st day of last menses? _____
Length between periods? _____Days
Are cycles regular? Y P N
Duration of bleeding/period? _____Days
Bleeding between periods? Y P N
Painful menses? Y P N
Heavy or excessive flow? Y P N
PMS? Y P N
If yes, what are your symptoms?
_____
_____

Birth control? Y N
What type? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____

Abnormal PAP history? Y P N
Cervical dysplasia? Y P N
Have you had any gynecological surgeries?
_____
_____

Endometriosis? Y P N
Ovarian cysts? Y P N
Fibroid tumors? Y P N
Fertility problems? Y P N
Sexually transmitted diseases? Y P N

Menopausal symptoms? Y P N
Do you do breast self-exams? Y P N
Have breast lumps? Y P N
Breast pain or tenderness? Y P N
Nipple discharge? Y P N
Fibrocystic breasts? Y P N

Male Reproductive System

Any discharge or sores? Y P N
Testicular pain? Y P N
Testicular masses? Y P N
Erectile dysfunction? Y P N
Number of children? _____

Prostate problems? Y P N
Hernia history? Y P N
Sexually transmitted diseases? Y P N
Birth control _____

Special Studies

What imaging or other special studies have you had pertaining to your current problem(s), within the past year?

_____

_____

_____

Hospitalizations and Surgery

What surgeries have you had and when?

_____

_____

When have you been hospitalized and what for?

_____

_____

Screenings:

Date of last physical exam? _____ Colonoscopy? _____

Males: Prostate exam_____ **Females**: Date of last PAP?_____Mammogram?_____

Family History

Please note if any of these disease/ problems are/ were applicable to your parents, grandparents, uncles, aunts, siblings or children. Please not for whom it was a problem.
Cancer & Type
Diabetes
Heart Disease
High Blood Pressure
Strokes
Mental Illness

Are your parents, grandparents, siblings and children all still living? If not, please put their cause of death and at what age(s), if you know?

_____

_____

_____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Beverages: _____

For the following sections, please use this key:

Y= a condition you have now N= a condition you have never had P= had in the past

Main interest and hobbies: _____

Do you exercise? YES NO If yes, what kind? _____

How often? _____ How much time spent per week? _____

Average 7-8 hours sleep?	Y N	Spend time outside?	Y N
Sleep well?	Y N	Watch television?	Y N
Awaken rested?	Y N	How many hours/ day? _____	
Have a history of any abuse?	Y N	Read?	Y N
Any major traumas?	Y N	How many hours/ day? _____	
Do you eat at least three meals a day?	Y N	Use alcoholic beverages?	Y N
Do you eat out often?	Y N	How much, how often? _____	
Do you go on diets often?	Y N	Treated for alcoholism?	Y P N
Do you drink coffee?	Y N	Do you drink cola or other sodas?	Y P N
Do you drink black or green tea?	Y N	Do you add salt to your food?	Y N
Do you eat refined sugar?	Y N		

Do you travel often for work? Y N

Are you exposed to any chemicals of occupational hazards as a part of your day or work?

_____

When during the day is your energy the best? _____ The worst? _____

How do your current conditions affect you?

_____

_____

What do you feel needs to happen to you to feel better/ get better?

_____

Is there any information about your health that you would like to add?

_____

I certify that the information given on this form is true and correct. I understand that this information will be used for the purpose of a natural medical consultation. I acknowledge by my signature that I have read and understand these statements.

_____

Signature Date

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Out of respect for our chemically sensitive patients

THIS IS A FRAGRANCE FREE OFFICE

Please refrain from wearing perfume, after shave and scented body lotions on the day of your treatment

Thank you for your understanding

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Informed Consent

I hereby request and consent to acupuncture treatments and other procedures within the scope of practice of Licensed Acupuncture for myself (or the patient named below, for whom I am legally responsible) by the acupuncturist named above.

I have been informed and understand that, as in the practice of medicine, the practice of Acupuncture entails some risks with treatment, including but not limited to slight bruising, tingling near the needling sites that may last a few days, nausea, a punctured lung or other internal organ, and infection. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications which may be possible, and I choose to rely on her expertise to exercise appropriate judgment during the course of the procedure which she deems appropriate at the time, and based upon the facts then known, in my best interest. If I suspect that I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reaction(s) to herbs, I will promptly inform the acupuncturist.

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the acupuncture procedure. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X_____ _____
Signature of Patient or Patient's Representative Date

X_____ _____
Print Name of Patient Print Name of Patient Representative

I acknowledge that a 1.5% fee will be added to any balance over 30 days past due.

X_____
Initials

I realize that I am responsible for a payment in full for a missed appointment charge if less than 24 hours notice is given for changing a scheduled appointment. A 1.5% fee will be added to any balance over 30 days past due. If your account is in arrears over 90 days it will be turned over to a collection agency.

X_____
Initials

I understand that if, for any reason, my insurance does not cover my acupuncture sessions, that payment is my personal responsibility, and that I will provide such payments.

X _____
Signature

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, HEREBY STATES that by signing below, I acknowledge and agree as follows:

The Practice's Privacy notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operation. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing the Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, **in writing,** at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

X_____ **X**_____
Name of Individual (Print) Signature of Individual

X_____ **X**_____
Signature of Legal Representative Relationship
(e.g. Attorney, Guardian, Parent if a minor)

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It is the office policy to keep your credit card on file in order to secure your appointments. As you know, our office is very busy and keeps a waiting list. If you miss your appointment, that is a time slot we could have offered another patient.

Your credit card information is kept in a secure, locked file and will only be used if you cancel with less than 24 hours-notice or don't keep the time we've allotted specifically for your care.

We hope you understand that this policy is in place so we can continue to put your healthcare first and serve you with the respect, focus and intention you deserve.

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Credit Card Authorization Form

PLEASE NOTE THIS AUTHORIZATION WILL ONLY BE USED FOR MISSED APPOINTMENT FEES AND UNPAID BALANCES.

Credit Card Details

Credit Card # _____

Expiration Date _____

CVC _____

Credit Card Holder Name _____

Billing Address

Street _____

City_____ State_____ Zip_____

Acknowledgement & Agreement

I hereby authorize my signature to be on file with Elixir Lifestyle Medicine for the purpose of client sessions that I schedule but fail to keep without providing 24 hours notice. I understand that all credit card transactions are subject to a $5 fee. I authorize the respective credit card company designated by my card on file to accept this form in lieu of my signature appearing on the individual credit card receipt for the services provided. By signing the authorization form, I acknowledge and agree to be financially responsible for any and all charges invoiced to me by Elixir Lifestyle Medicine. I confirm that I am the credit card holder responsible for the credit card number I have indicated. I agree to permit Elixir Lifestyle Medicine to submit unsigned credit card vouchers, stating that my signature is on file, or to amend, alter, complete or execute on my behalf, credit card vouchers in my name for payment of charges. I further agree that in the event my credit card becomes invalid, I personally guarantee payment and will provide Elixir Lifestyle Medicine with a new valid credit card number upon request, to be charged for the payment of any outstanding balances owed.

_____
Card Holder Signature

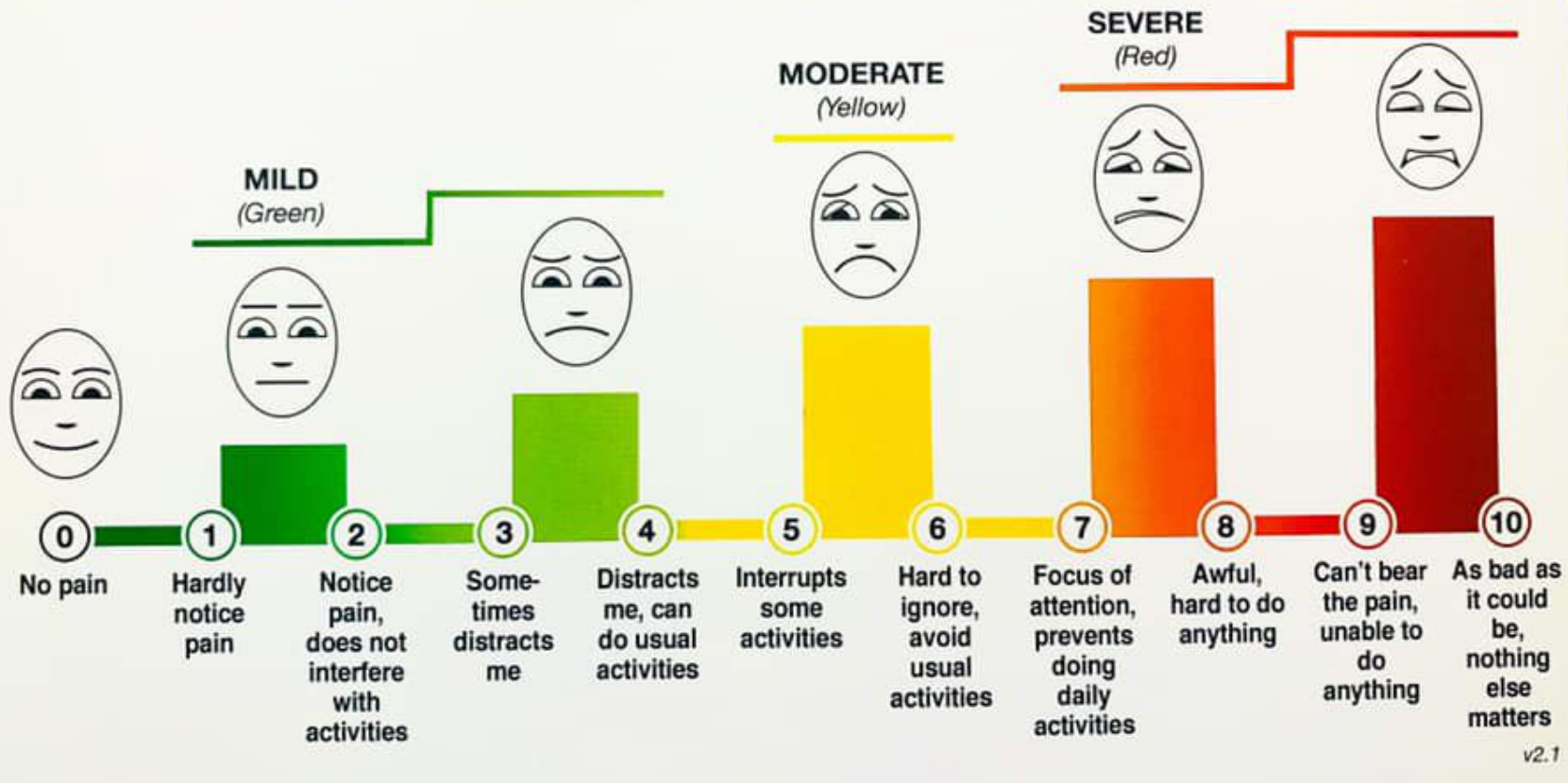
_____ _____
Print Name Date

American Society of Acupuncturists

www.ASAcu.org

Look at the **"Defense and Veterans Pain Rating Scale"** **and read the descriptions** under each number. Please rate the severity of your **CURRENT PAIN** by ***circling the corresponding number (0 to 10).***

Defense and Veterans Pain Rating Scale



Adve

rse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever…
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____

4. Did you **often** feel that …
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____

5. Did you **often** feel that …
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____

7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 _____

10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score