

Alamo Heights Wellness

HEAL WELL

Patient Confidential Information

Name: _____
First Middle Last

Address: _____
Street

City State Zip

Primary Phone (number you would like called for appointment reminders):

Bus Phone: _____ Home: _____ Cell: _____

E-mail: _____

May practitioner contact you via E-mail? YES/ NO

Age: _____ Date of Birth ___/___/____ Sex: M/ F Marital Status: S M D W

Place of Birth: _____ Occupation: _____

Employer: _____

Whom may we thank for referring you to our office?

In case of emergency, call:

Name Relation

Home Phone : _____ Business Phone : _____

Cancellation Policy

Out of respect for the practitioner's time and in order to maximize availability to patients, a minimum of 24 hours notice for cancellations is required. Not providing 24 hours notice, not showing, or being more than 20 minutes late for an appointment results in a charge of the standard fee to your account. Compliance with this policy enables better service to you and other patients. Thank you for your understanding.

Patient Signature Date

Medical History Questionnaire

Please complete the following as completely and accurately as possible.

Name: _____ Date: _____

Present Illness/Injury:

What is your chief concern?

When did this condition begin?

What treatment have you received already?

Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had? When?

What allergies, if any, do you have?

What medications are you taking (include dosages) (please include non-prescription)?

What supplements are you taking (include dosages)?

Have any of your blood relatives had any of the following?

- stroke cancer heart disease tuberculosis bleeding disorder
 diabetes high blood pressure thyroid disorder

When was your last physical exam? Were any abnormalities found? Please explain.

Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered “primary health care”. As a result, Alamo Heights Wellness is required to have you respond to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these is no.

I (patient’s name) _____ am notifying the practitioner at Alamo Heights Wellness of the following:

____ Yes ____ No I have been evaluated by a physician or dentist for the condition being treated within 12 months before acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

____ Yes ____ No I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.

It is my responsibility and choice whether to follow this advice.

OR

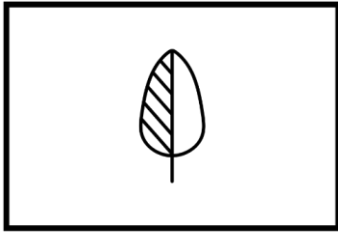
I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

- ____ Chronic Pain
- ____ Smoking Addiction
- ____ Weight loss
- ____ Alcoholism
- ____ Substance Abuse

Patient Signature Required

Date

Alamo Heights Wellness is not responsible for untrue statements made by patients.



Alamo Heights Wellness

HEAL WELL

Our process, proven over 14 years of experience and over 3,000 patients, is designed to get the best results in the least amount of time possible. It involves **THREE** main strategies: **Acupuncture, Nutritional Therapy, Herbal Therapy**. When applied together they are extremely effective for unifying and strengthening your body's healing system on ALL possible levels.

We will always incorporate your feedback and do our best to make your experience as easy and cost-effective as possible.

To help us serve you better, please indicate your preferences below by checking the box next to the answer that best fits you:

- Yes, please tell me which strategies will be the most helpful for me based on your experience, and I will do it. (most popular)**

Or.... Specify below:

1. I am interested in receiving **Acupuncture** treatments:
 Yes No
2. I am interested in **Nutritional Therapy** (investment in supplements is between \$30-\$100 a month for the first 2-3 months)
 Yes, please tell me what you think I should do based on your experience, and I will do it.
 Yes, but I have budgetary constraints so please be aware of this when recommending nutritional options.
 Yes, but I don't want to take a lot of pills so keep it to a minimum.
 No, I don't want any nutritional supplements.
3. I am interested in **Herbal Therapy**:
 Yes, please tell me what you think I should do based on your experience, and I will do it.
 Yes, but I have concerns about your sourcing so please explain why your herbs are safe for me to take.
 No, I would rather not take any herbs.

Name: _____

Signature: _____