

**Hayden Acupuncture
 & Wellness Center**
 6239 E. Brown Rd. #118
 Mesa, AZ 85205
 480-832-2250

PATIENT INFORMATION

Name: (last, first, initial)		
Street Address:		
City, State, Zip:		
Mobile Phone:	Home Phone:	Work Phone:
Email:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Employers Name:		Occupation:
Spouse / Partner:		Phone:
Emergency Contact Name:		Phone:
Phone # & Address where it is okay to contact you – <i>if different from above:</i>		
Responsible Party Information: <input type="checkbox"/> Self/Same as above		Relationship to Patient:
Name: (last, first, initial)		
How Did You Hear About Us?:		

*I authorize you to release information regarding my care and treatment to the following:

*You may speak to on the phone or in person regarding my care and treatment to the following:

I certify that the information provided is true and accurate. I assign any payable benefits to be paid directly to Hayden Acupuncture & Wellness Center and authorize them to submit a claim on my behalf and release any information required to obtain payment for my care and treatment.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF SERVICE.

Signature

(Relationship to Patient)

Date

Focus

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities (check all that apply):

- | | | | |
|----------------------------------|--|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Work | <input type="checkbox"/> Standing | <input type="checkbox"/> Sexually | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Emotionally | <input type="checkbox"/> Recreation | _____ |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Relationships | <input type="checkbox"/> Bending | _____ |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Social Life | <input type="checkbox"/> Stretching | _____ |

What have you done about this? _____

Have you had Acupuncture before? Y/N

Are there any other therapies which you are involved in? Y/N

With whom and what therapy? _____

Are you interested in:

- | | | | |
|--|---|--|--------------------------------|
| <input type="checkbox"/> Pain Relief | <input type="checkbox"/> Healy | <input type="checkbox"/> Energy Balancing | <input type="checkbox"/> Other |
| <input type="checkbox"/> Stress Reduction | <input type="checkbox"/> Laser Therapy | <input type="checkbox"/> Maintenance Care | _____ |
| <input type="checkbox"/> Chinese Herbs | <input type="checkbox"/> Asian Bodywork | <input type="checkbox"/> Preventative Care | _____ |
| <input type="checkbox"/> Nutritional Information | <input type="checkbox"/> Cupping | <input type="checkbox"/> Performance Care | _____ |

What are your health goals? _____

List exercise and sport activities you have been or are currently involved in:

Female Concerns

Date of last period: _____ ~OR~ Date of Menopause: _____

Age period started: _____ Is / Were your cycles regular? Y/N Is / Were your cycles painful? Y/N

Have you ever been pregnant? Y/N Number of times: _____ Number of live births: _____

Birth control? Y/N How long? _____ PMS Clotting Vaginal sores Vaginal pain Discharge

Date of last Pap and breast exam: _____ Results normal? Y/N

Male Concerns

Date of last prostate check: _____ Urinary problems: _____

Erection difficulties: Y/N Type and for how long: _____

Signs/Symptoms

Please check all that apply:

- | | | | | |
|--|---|--|---|---|
| <input type="radio"/> Abdominal pain or distention | <input type="radio"/> Dark stools | <input type="radio"/> Hemorrhoids | <input type="radio"/> Muscle cramps, pain | <input type="radio"/> Redness of eyes |
| <input type="radio"/> Abuse survivor | <input type="radio"/> Decreased libido | <input type="radio"/> Heart palpitations | <input type="radio"/> Nasal congestion | <input type="radio"/> Seeing a therapist |
| <input type="radio"/> Acid regurgitation | <input type="radio"/> Depression | <input type="radio"/> Hiccups | <input type="radio"/> Neck / shoulder pain | <input type="radio"/> Short temper |
| <input type="radio"/> Acne | <input type="radio"/> Dizziness / vertigo | <input type="radio"/> Impotence | <input type="radio"/> Night sweats | <input type="radio"/> Shortness of breath |
| <input type="radio"/> Bad breath | <input type="radio"/> Dry throat or mouth | <input type="radio"/> Increased libido | <input type="radio"/> Nocturnal emission | <input type="radio"/> Sinus pressure |
| <input type="radio"/> Blood in stools | <input type="radio"/> Diarrhea | <input type="radio"/> Indigestion | <input type="radio"/> Nose bleeds | <input type="radio"/> Skin fungal infection |
| <input type="radio"/> Blood in urine | <input type="radio"/> Earaches | <input type="radio"/> Intestinal cramps | <input type="radio"/> Numbness | <input type="radio"/> Spots in eyes |
| <input type="radio"/> Blurry vision | <input type="radio"/> Eye pain or strain | <input type="radio"/> Irritability | <input type="radio"/> Odorous stools | <input type="radio"/> Sweat easily |
| <input type="radio"/> Breast lump or pain | <input type="radio"/> Excessive phlegm | <input type="radio"/> Itchy eyes | <input type="radio"/> Pain upon urination | <input type="radio"/> Sore throat |
| <input type="radio"/> Bruise easily | <input type="radio"/> Excessive saliva | <input type="radio"/> Itchy skin | <input type="radio"/> Peculiar tastes | <input type="radio"/> Sudden energy drop |
| <input type="radio"/> Chest pains | <input type="radio"/> Fatigue | <input type="radio"/> Joint pain | <input type="radio"/> Poor appetite | <input type="radio"/> Swollen glands |
| <input type="radio"/> Chills | <input type="radio"/> Fever | <input type="radio"/> Kidney stones | <input type="radio"/> Poor circulation | <input type="radio"/> Teeth / gum problems |
| <input type="radio"/> Cold hands or feet | <input type="radio"/> Frequent urination | <input type="radio"/> Knee pain | <input type="radio"/> Poor memory | <input type="radio"/> Ulcerations |
| <input type="radio"/> Concussion | <input type="radio"/> Gas / belching | <input type="radio"/> Laxative use | <input type="radio"/> Poor sleep | <input type="radio"/> Upper back pain |
| <input type="radio"/> Confusion | <input type="radio"/> Goiter | <input type="radio"/> Loss of hair | <input type="radio"/> Premature ejaculation | <input type="radio"/> Urgent urination |
| <input type="radio"/> Constipation | <input type="radio"/> Grinding teeth | <input type="radio"/> Low back pain | <input type="radio"/> Premature graying | <input type="radio"/> Vomiting |
| <input type="radio"/> Cough | <input type="radio"/> Hay fever | <input type="radio"/> Mouth sores | <input type="radio"/> Psoriasis | <input type="radio"/> Wake to urinate |
| <input type="radio"/> Coughing blood | <input type="radio"/> Headache | <input type="radio"/> Mucous in stools | <input type="radio"/> Rash | <input type="radio"/> Weight loss / gain |
| | | | | <input type="radio"/> Wheezing |

Please indicate if you have or had any of the following conditions:

- | | | | |
|---|---|---|--|
| <input type="radio"/> Pneumonia | <input type="radio"/> Mental illness | <input type="radio"/> Lupus | <input type="radio"/> HIV / Aids |
| <input type="radio"/> Tuberculosis | <input type="radio"/> Mental breakdown | <input type="radio"/> Diabetes | <input type="radio"/> STD's |
| <input type="radio"/> Asthma | <input type="radio"/> Depression | <input type="radio"/> Hypo / Hyperthyroid | <input type="radio"/> Gout |
| <input type="radio"/> COPD / Emphysema | <input type="radio"/> Anxiety / panic | <input type="radio"/> Kidney disease | <input type="radio"/> Plantar fasciitis |
| <input type="radio"/> Valley fever | <input type="radio"/> Fibromyalgia | <input type="radio"/> Chronic UTI's | <input type="radio"/> Arthritis |
| <input type="radio"/> Heart attack | <input type="radio"/> Migraines | <input type="radio"/> Cystitis | <input type="radio"/> Other auto-immune diseases |
| <input type="radio"/> High blood pressure | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Enlarged prostate | _____ |
| <input type="radio"/> Low blood pressure | <input type="radio"/> Seizures / Epilepsy | <input type="radio"/> GERD | _____ |
| <input type="radio"/> Heart disease | <input type="radio"/> Bells Palsy | <input type="radio"/> Ulcers | <input type="radio"/> Cancer |
| <input type="radio"/> CHF | <input type="radio"/> Neuropathy | <input type="radio"/> IBS | _____ |
| <input type="radio"/> High cholesterol | <input type="radio"/> Lyme disease | <input type="radio"/> Crohn's disease | _____ |
| <input type="radio"/> Stroke / TIA | <input type="radio"/> Shingles | <input type="radio"/> Hepatitis | _____ |

Do you sleep well? Y/N Do you dream? Y/N

Do you have a high point during the day? Y/N When? _____

Do you have a low point? Y/N When? _____

What are your indulgences?

What are your hobbies or recreational activities?

Web of Wellness

Our health and overall personal wellness are a combination of many factors. Each individual aspect of our lives can either contribute to our health and well-being, or create stress, disease or illness.

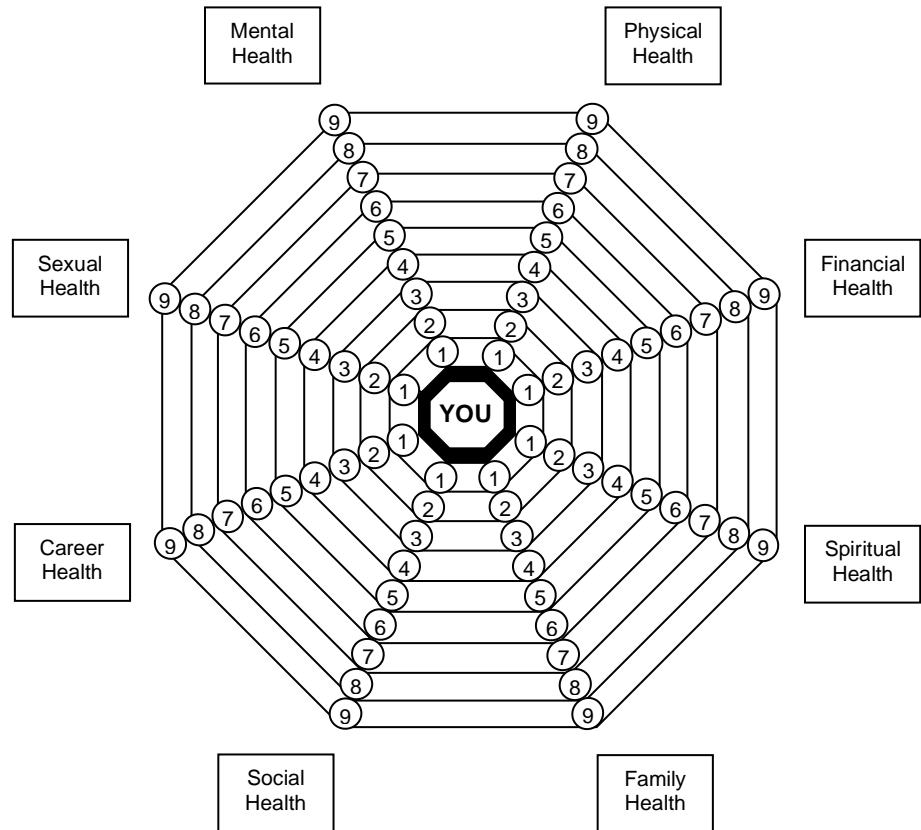
Using the diagram to the right, and starting at the center, choose your level of satisfaction in each area.

For example:

If you are extremely satisfied with your career, shade in the #9 circle in the career line.

1 = Not happy

9 = Extremely happy



Pain

Pain intensity levels (please indicate below which best describes)

No pain Moderate pain Severe pain Extreme pain

Sleeping

No problem Mildly disturbed Greatly disturbed Cannot sleep

Work – Capacity you are able to work at

100% 75% 50% 25% Unable to work

Frequency of pain

25% of time 50% of time 75% of time 100% of time

Travel

No problem on long trips Moderate pain on trips Severe pain

Sitting

No pain sitting Some pain while sitting Cannot sit without pain

Recreation

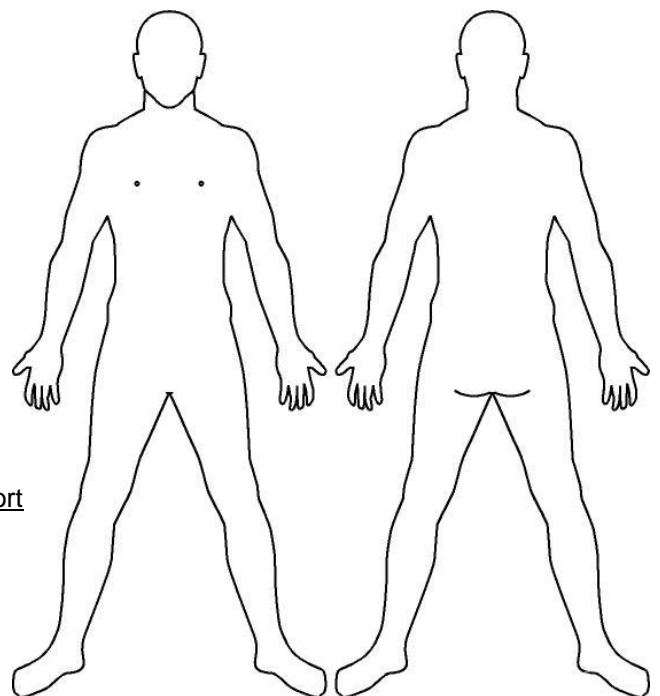
No problem Mild discomfort Moderate discomfort Severe discomfort

Walking

Can walk any distance Pain in less than 30 minutes Cannot walk

Body Chart

Please indicate areas of pain, tension, tightness, or discomfort on the body chart with 'X's'.



Cancellation and Late Policy

We all hate to hurry up and wait, that is why here at Hayden Acupuncture & Wellness Center we will do everything in our power to ensure that you are seen at your scheduled appointment time. Emergencies could possibly arise which would require our immediate attention, and we appreciate your patience during these times. Remember, the emergency could be yours at some point.

This being said, our policy here at the Center on being late is this: you have a scheduled time slot and you will receive your treatment during that time. Because you are late your time slot has not changed. This is to ensure that the patient after you is seen at their scheduled time and doesn't have to wait. If there is time available after your scheduled appointment and you would like to add to your treatment time, there is a charge (billed in increments of 15 minutes). So please keep in mind traffic and other events and plan accordingly to give yourself plenty of time to get here calmly and safely.

Our policy on cancellations is a minimum 24 hour courtesy notification phone call (NOT a text or email), from the patient or patient representative. Keep in mind that we are closed on Sunday and a call on that day to cancel a Monday appointment will not count. Failure to give a 24 hour notice will result in a No Show/Late Cancellation fee up to the cost of your session that will be billed to you or applied to your next appointment fee. Multiple No Show/Late Cancellations WILL result in prepayment for any future scheduled appointments.
*****Please note that you cannot cancel your appointment from Schedulicity.**

Acknowledgement of Receipt of Privacy Practices Notice

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Hayden Acupuncture & Wellness Center's "Notice of Privacy Practices;" revision date 11/23/2012. As required by the Privacy Regulations, the staff of Hayden Acupuncture & Wellness Center have explained the "Notice of Privacy Practices" to my satisfaction. As required by the Privacy Regulations, I am aware that Hayden Acupuncture & Wellness Center has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Signature

Date

Print Name