Vitality

WELLNESS CENTER

Name: _____ Date: _____
First Last

Birthdate: _____-_____-_____ Age: _____

Mailing Address: _____

_____
City State Zip Code

Home: (_____) _____ - _____

Cell #: (_____) _____ - _____

E-mail Address: _____

In case of emergency contact:

Name: _____

Relationship: _____

Home: (_____) _____ - _____

Cell #: (_____) _____ - _____

Referred By: _____

Employer/ School: _____

Occupation: _____

Health Status:

Are you in pain: ○ YES ○ NO Rate your pain: DISCOMFORT 1 2 3 4 5 6 7 8 9 10 INTENSE

When did your condition/accident occur: _____

Where did your injury occur: _____

Please explain what happened: _____

_____

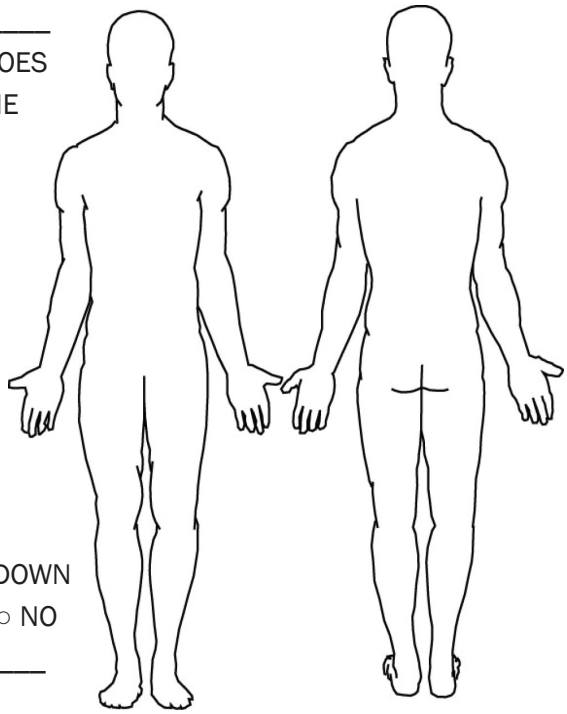
Is your condition getting worse: ○ YES ○ NO ○ CONSTANT ○ COMES & GOES

Is your condition interfering with your: ○ WORK ○ SLEEP ○ DAILY ROUTINE

If so how: _____

Has this or something similar happened in the past? ○ YES ○ NO

Explain: _____



Using the adjacent body, please circle all the affected areas:

Type of pain is : ○ SHARP (S) ○ BURNING (B) ○ THROBBING (T)

○ NUMBNESS (N) ○ ACHING (A) ○ SHOOTING (Sh) ○ TINGLING (Ti)

○ CRAMPING (C) ○ STIFFNESS (St) ○ SWELLING (Sw) ○ DULL (D)

Any range of motion limitations: _____

Any pain while: ○ SITTING ○ STANDING ○ WALKING ○ BENDING ○ LAYING DOWN

Have you been treated by a Medical Physician for this condition: ○ YES ○ NO

If so, where: _____

What treatment have you already recieved for your condition:

○ MEDICATIONS ○ SURGERY ○ PHYSICAL THERAPY ○ NONE ○ OTHER: _____

Health History

Please indicate if you have any of the following:

- ○ ABNORMAL BLEEDING | where:
- ○ ADDICTION | type:
- ○ ALLERGIES | type: airborn, food, shellfish
- ○ ANEMIA | type:
- ○ ARTHRITIS | where:
- ○ BACK PAIN | where:
- ○ CANCER | type:
- ○ CARDIOVASCULAR DISEASE
- ○ DIABETES |type:
- ○ DIGESTION | indigestion, bloating, gas, heartburn, pain diarrhea, constipation, irritable bowl syndrome or disease, Cronhs disease, Celiacs, colitis, other:
- ○ DIZZINESS | when:
- ○ EAR DISORDERS |type:
- ○ EYE DISORDERS |type:
- ○ EMOTIONAL ISSUES | depression, anxiety, bipolar other:
- ○ EPILEPSY | how often:
- ○ FREQUENT COLDS / FLU |how often:
- ○ FATIGUE / WEAKNESS | when:
- ○ GALLSTONES |removed:
- ○ HAIR |unexpected hair loss, if hair is graying, when did it start:
- ○ HEADACHES | sinus, tension, migraine, unsure how often:
- ○ HEART PALPITATIONS |how often:
- ○ HEPATITIS | type:
- ○ BLOOD PRESSURE | high, low
- ○ HIV + | how long:
- ○ JOINT PAIN | where:
- ○ LOW LIBIDO | how long:
- ○ PROSTATE DISORDERS | how long:
- ○ RESPIRATORY DISORDERS |asthma, bronchitis, pnemonia, chronic cough, other:
- ○ STD's | type:
- ○ SINUS ISSUES |type:
- ○ SKIN ISSUES | eczema, psoriasis, acne, dryness, other:
- ○ THYROID | hypothyroidism, hyperthyriodism
- ○ URINARY/ KIDNEY | kidney stones, kidney infection, UTI, urinate frequently, incontinence, pain, blood in urine, urinary difficulty

Do you have a tendency to feel cold or warm relative to other people: ○ NO ○ COLDER ○ WARMER

Do you have an aversion to hot or cold weather: ○ NO ○ COLD ○ HOT Are you often thirsty: ○ YES ○ NO

Do you practice any stress management techniques: ○ YES ○ NO Do you take recreational drugs: ○ YES ○ NO

How many hours do you sleep: _____ Do you have vivid dreams: ○ YES ○ NO Is it difficult to fall asleep: ○ YES ○ NO

Do you wake in the night: ○ YES ○ NO Why:_____ If so, do you fall back asleep easily: ○ YES ○ NO

Exercise

- ○ NONE
- ○ MODERATE
- ○ DAILY
- ○ HEAVY

Work activity

- ○ SITTING
- ○ STANDING
- ○ LIGHT LABOR
- ○ HEAVY LABOR

Habits

- ○ SMOKING Packs/Day: _____
- ○ ALCOHOL Drinks/Week: _____
- ○ CAFFEINE Cups/ Day: _____
- ○ ↑ STRESS Reason: _____

What foods do you eat for each of the following: ○ Snacks:

○ Breakfast: ○ Lunch: ○ Dinner:

Any Dietary Restrictions:

List any past injuries and surgeries: *Description* *Date*

_____ _____

_____ _____

_____ _____

Please list any medications and reason:

_____

_____

_____

Any nutritional supplements and herbs:

_____ _____

_____ _____

_____ _____

Woman's Health History:

Date of last gynecological exam: _____

Have you ever had an abnormal PAP: ○ YES ○ NO
Is there a chance you are pregnant: ○ YES ○ NO
Do you use oral contraceptives: ○ YES ○ NO

At what age did your menstral cycle start: _____
At what age did your menstral cycle stop: _____
What is the date of your most recent period: _____
How many days does your period last: _____
How many days pass from the start of one period to the start of the next: _____
Does this time vary by more than two days per cycle: ○ YES ○ NO
Do you consistently have spotting for 2 or 3 days before your menses: ○ YES ○ NO
Do you have blood clots or tissue in your menses: ○ YES ○ NO
In general, how would you describe the color of your menses:

○ FRESH RED ○ BRIGHT RED ○ DARK RED ○ PURPLISH ○ PALE ○ WATERY

Do you experience any of the following before, during, or after your menses:

○ ABDOMINAL PAIN ○ CRAMPING ○ LOW BACK PAIN○ GENERAL BODY ACHES ○ HEADACHES ○ DEPRESSION
○ BREAST TENDERNESS ○ BREAST SWELLING ○ WATER RETENTION ○ FATIGUE ○ IRRATABLITY ○ ANXIETY

Do you have unusual discharge or laction from your nipples:

Have you ever had a diagnosis of endometriosis: ○ YES ○ NO
Have you ever had a diagnosis of polycysitic ovarian syndrome: ○ YES ○ NO
Have you ever had a diagnosis of uterine fibroids (myoma): ○ YES ○ NO
Have you ever had a diagnosis of pelvic inflammatory disease: ○ YES ○ NO

Number of pregnancies: _____
Number of births: _____
Number of miscarriages/abortions: _____
Was conceptions difficult: ○ YES ○ NO
Did any health issues arise during any pregnancy / labor / delivery: ○ YES ○ NO

If you are currently trying to conceive, answer the following questions:

How long have you been trying: _____
Have you seen a western fertility specialist: ○ YES ○ NO
If so, who: _____
Do you track your ovulation: ○ YES ○ NO
by: ○ URINARY LH STICK ○ BASAL BODY TEMPERATURE ○ CERVICAL MUCUS
If so, do you ovulate on a regular basis each month: ○ YES ○ NO
Do you have any blood relatives who have had a stroke, heart attack, or any other blood clotting related disorder before 50 years old: ○ YES ○ NO
Do you have any blood relatives who have had a diganosis of an autoimmune disease (multiple sclerosis, lupus, reynauds, rheumatoid arthritis, etc): ○ YES ○ NO
Do you have a male partner: ○ YES ○ NO
If yes, what is his age: _____
Has he has a semen anyalysis: ○ YES ○ NO

Informed Consent for Acupuncture Treatment

The nature of acupuncture treatment: Some patients feel a bit light headed after a treatment. If this happens, please tell us. Even if you do not feel dizzy after a treatment, it is a good idea to take a few minutes to breathe deeply and regroup before heading out the door.

Herbal prescriptions and patent medicines are intended ONLY for the person for whom they are prescribed. Do NOT give your herbs to anyone else, even if it appears they have a condition similar to yours. State and local sales taxes are included in the price charged for herbs and herbal products.

Possible risks: Acupuncture needles may occasionally cause a small bruise. This is typically not cause for concern; however do call if you experience lingering discomfort or discoloration at the site of needle insertion. Only pre-sterilized, single use, disposable needles are used in this office.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic office listed below, or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedure. I intend 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.

Alana Ramey-Bernardi, L. Ac., CMT • 831 . 325 . 9691

Neil Bernardi-Wright, L. Ac., FABORM • 408 . 402 . 1849

1011 Center St., Santa Cruz CA 95060 • 15251 National Ave, Ste. 106, San Jose CA 95035

Name: _____ Date: _____

Signature: _____

HIPAA Compliance Authorization
Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we deem are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. Unless you provide us in writing that you refuse, you agree that this office can share needed information about your treatment plan with your referring family physician and/or physician that you are being referred to.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, attorneys, collection agencies, law enforcement officials, worker's compensation, etc.), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You, as the patient, have the right to receive one free copy of your medical records from this and any office where you have sought or received treatment.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restriction, and to revoke consent in writing after you have reviewed our privacy notice.

I acknowledge that I have received a HIPAA Compliance Assurance Notification.

Name: _____ Date: _____

Signature: _____

Alana Ramey-Bernardi, L.Ac. // Neil Bernardi- Wright L.Ac. FABORM // 1011 Center St. Santa Cruz CA 95060

Compliance Assurance Notification

To our valued patients: The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us to prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients!

Cancellation Policy & No-Show Policy

Please inform us at least 24 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients who may have an immediate need for care.

Please be aware that a $30.00 cancellation fee will be assessed if you are a no-show or fail to cancel with in 24 hours of your appointment.

Our acupuncture appointments generally take 50 + minutes. If you arrive more than 15 minutes late, this will count as a missed appointment. Unfortunately, we cannot guarantee that "late comers" will receive full time for their treatment.

In the case of an unavoidable emergency, this fee may be waived. If you have any questions, don't hesitate to ask.

Please accept below to acknowledge your understanding of our cancellation policy.

Name: _____ Date: _____

Signature: _____

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