Preferred Client Information

Name: (Mr./Mrs./Ms.) circle one **Date:___/___/_____**

Last:_____ ***First***:_____

Birth Date: ___/___/_____ ***Current Age:***____ ***Profession:*** _____

Married / Partnered / Single / Divorced / Widowed *Number of Children* _____

Contact Information:

Telephone: Work:_____ Home:_____

Email:_____ Cell:_____

Can we send appointment reminders to your cell via text? (Yes / No) Provider_____

(ex: Sprint, AT&T, etc.)

***Address*:**

Line1:_____

City:_____ State: _____ Zip:_____

Emergency Contact:

Name:_____ Relation: _____Phone:_____

Were you referred to us by someone? (Y / N) circle one

If yes, by whom? _____
If no, how did you hear about us? _____

What is your chief complaint? _____

What are your other major complaints? _____

Have you ever had: a seizure? (Y / N) a stroke or brain bleed? (Y / N) a major head injury? (Y / N)

Do you have any children / nieces / nephews / grandchildren with health challenges (mental / emotional / physical)? _____

Bene VIDA
HEALTH + WELLNESS CENTER

CHECKLIST OF CLIENT CONCERNS

NAME:

DATE: PRE/ONGOING/POST DATE:

Below is a list of problems that clients frequently describe to us. Please check off any that match your current concerns. If you are not sure whether to endorse an item, use the past week as a guide. Feel free to add any comments as necessary. Thank you.

Immune System
1. Allergies
2. Asthma
3. Frequent colds, infections
4. Yeast infections
5. Fatigue

Sleep
6. Difficulty falling asleep
7. Wakeful or restless during night
8. Waking up early
9. Difficulty waking up
10. Nightmares or night terrors
11. Snoring
12. Sleep walking

Skin/Hair/Nails
13. Problems with skin
14. Hair
15. Nails

Eyes
16. Double or blurred vision
17. Blind spots
18. Spots in your vision

Ear/Nose/Throat
19. Hearing loss
20. Ringing in ears
21. Earaches
22. Sense of smell changed or lost
23. Nose or sinuses blocked
24. Grinding your teeth
25. Sense of taste changed or lost
26. Hoarseness or sore throat

Heart/Lungs
27. Problems breathing
28. Heart problems
29. Hypertension
30. Palpitations
31. Dizziness

Intestines
32. Nausea or vomiting
33. Gastric pain
34. Gas or bloating
35. Irritable bowel
36. Diarrhea
37. Constipation

Hormonal/Blood
38. Appetite problems (e.g. wanting to eat when not hungry, etc)
39. Diabetes
40. Desire for sweets or carbohydrates
41. Sensitivity to heat or cold
42. Thyroid problems
43. PMS symptoms
44. Hot flashes
45. Other menopausal symptoms
46. Low interest in sex
47. Excessive interest in sex

Bones/Joints/Muscles
48. Pain or stiffness in joints or muscles
49. Sore trigger points
50. Fibromyalgia
51. Bodily fatigue

Nervous System
52. Headaches or migraines
53. Fainting
54. Seizures
55. Memory loss
56. Blocking on words
57. Reading problems
58. Difficulty speaking
59. Tremor (shaking)
60. Weakness
61. Hyperactivity
62. Problems with balance
63. Motor or vocal tics

Attention and Organization
64. Difficulty focusing
65. Easily distracted
66. Make mistakes
67. Difficulty organizing activities
68. Not completing tasks
69. Lose train of thought

School/Learning
70. Difficulty completing schoolwork
71. Getting into trouble at school
72. Inverting letters/numbers
73. Spatial problems (e.g. difficulty building things, understanding how things should be put together)
74. Difficulty with particular subjects

Bowel/Bladder
75. Difficulty urinating
76. Difficulty holding your urine
77. Difficulty controlling your bowels
78. Frequent bladder infections

Habits
79. Sometimes drink too much
80. Smoke cigarettes
81. Concerns about your diet
82. Desire caffeine
83. Use marijuana
84. Other addictions

Behavior/Emotions
85. Mood swings
86. Feeling down, depressed or flat
87. Feeling sad
88. Feeling anxious
89. Panic attacks
90. Worry
91. Thoughts that won't leave your mind
92. Need to repeat actions or words over and over.
93. Bingeing
94. Restricting your food intake
95. Making yourself vomit
96. Phobias- avoiding things
97. Feeling others are against you
98. Behaviors that get you into trouble, or are not good for you
99. Feeling angry a lot
100. Impulsive
101. Feeling overwhelmed

List 3 things you do currently that support your overall health.

_____

_____

_____

List your 3 favorite vices (eg smoking, social drinking, sweet tooth…)

_____

_____

_____

Overall, do you feel that your lifestyle **contributes to OR takes away from** your health?

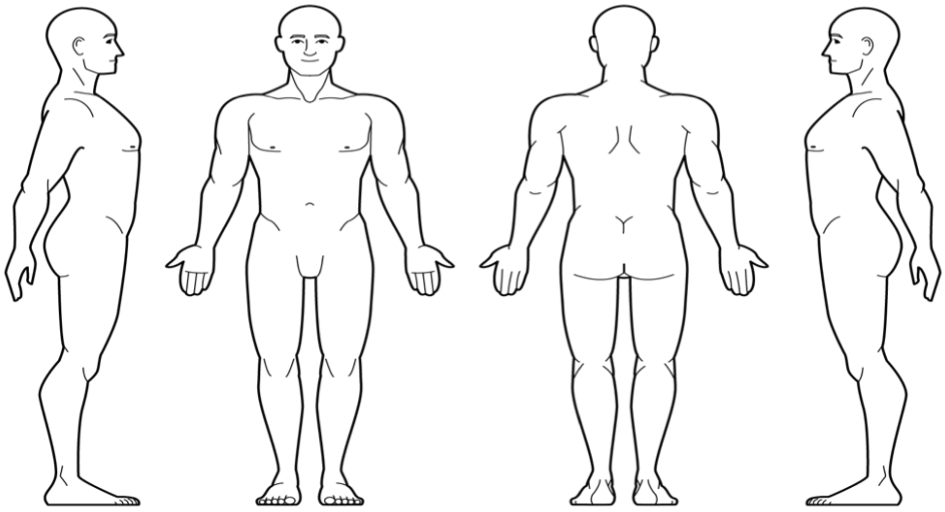
_____

_____ Soft drinks per day _____ Cups of tea per day _____ Cups of coffee per day _____ Glasses of water per day _____ Alcoholic beverages per week. Are you a vegetarian? Yes, strict ☐ No ☐ Yes, but not strict ☐

Pain and discomfort:

X – Sharp / Stabbing
P – Pins / Needles
D – Dull / Ache
N – Numbness
T – Tightness

1-10 Scale
(1=least; 10=most)



Medications & dose	Vitamins/Minerals/Herbs	Allergies

Informed Consent to Oriental Medical Healthcare

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Michael Meuth, licensed acupuncturist: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle, and orthopedic testing (modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation), the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendation; exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with my professional practitioner, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental Medicine procedures. Although I am aware that acupuncture and the other procedures used in Oriental Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implicated.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pneumothorax (punctured lung), puncture of other organs, pin or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise such judgment, during the course of my treatment, as the doctor feels as the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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 at Benevida Wellness.

Patient's name (please print)	Patient's signature
Date signed	Witness
Print name of patient's representative (if applicable)	Relationship or authority of patient's representative
Signature of patient's representative (if applicable)	Date signed

Benevida is not responsible for untrue statements made by patients.

Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirements of 22 T.A.C §183.7 of the Texas State Acupuncture Examiners' rules (relating to Scope of Practice) and Texas Code Ann., §205.351, governing the practice of acupuncture)

Choose only one of the three options below.

I (patient's name) _____ am notifying Michael Meuth, L.Ac. of the following:

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

_____ _____

Patient's signature (required) Date signed

OR

Yes ____ No ____ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic treatment prior to acupuncture treatment is _____. After being referred by a chiropractor, if after 60 days 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 to follow this advice.

_____ _____

Patient's signature (required) Date signed

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 one of the following conditions:

___Chronic Pain
___Weight Loss
___Smoking Cessation

_____ _____

Patient's signature (required) Date signed

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Benevida Wellness

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that Benevida "Notice of Privacy Policies" has been provided to me. I understand I have a right to review the "Notice of Privacy Policies" prior to signing this document. "The Notice of Privacy Policies" is also provided upon request.

Members of the staff may need to contact you with appointment reminders of information related to your treatment. If this contact is made by phone, and you are not at home, a message will be left on your answering machine or with whoever answers the phone. By signing this form you are giving us authorization to contact you with these reminders and information.

_____ _____

Patient Name Printed Date

_____

Patient Signature

48 Hour Cancellation Policy

We strive to make my office run as smoothly as possible and to help make your experience here as satisfying and pleasant as possible.

To do this, we allow plenty of time for your visit. Unlike many physicians' offices that schedule six to eight patients per hour to compensate for those who do not show up, we regularly see only one or two people per hour. In order for our office to run as smoothly as possible we ask that you give us ample notice if you cannot make your appointment.

Please note that we have a **48-hour** cancellation policy. Please bring your calendar in order to set up your follow-up appointments. If you need to reschedule your appointment at anytime during your series, please give us at least 48 hours notice so that your time slot can be used by other clients. If we do not receive at least 24 hours notice, you will be charged in full for your missed appointment. Naturally, we will make an exception to this in the event of genuine emergencies, such as acute illness or accidents. This policy is not intended to be punitive; it simply allows us to keep an appointment schedule that allows quality care for every client.

Please sign below to acknowledge that you have read my scheduling policy and that you accept these terms. Thank you for your understanding and compliance of this necessary policy.

Signature:_____ Date:_____