## Welcome to Angelo Chiropractic and Acupuncture Center

## "Where health and care come together."

Thank you for selecting our office for your holistic healthcare needs. We will determine if chiropractic/acupuncture and its associated treatments are indicated for your health condition. We strive to provide the highest quality of care possible. If our modes of care are not indicated or need to be co-managed, we will recommend a health care practitioner to best serve your condition. We treat patients of all ages, backgrounds, and needs. We treat families, newborns, athletes, expecting mothers, the injured and sick, and those that wish to maintain their health. We are HIPAA compliant; we will not release your medical information without written consent from you, unless it is regarding payment for your health services (i.e. insurance companies), or other health care professionals involved in your health care. A Privacy Policy and Informed Consent will be provided for your protection, review, and signature.

**Payment Policy**

Payment is due for fees incurred on the date of service. We offer a discount plan, if you pre-pay for five visits you will receive one visit free. If you pre-pay for ten visits, you will get three visits free. Payment must be paid in full for all visits in order to receive free visits. Immediate family members may be included in this plan.

**Timely Appointments**

I understand that when reserving an appointment that my doctor and I are reserving time for my care and if not utilized this prevents another from receiving care. Therefore, in order for Angelo Chiropractic and Acupuncture center to provide timely service to all patients, this office requires a 12-hour minimum cancellation notice. I agree that I am subject to a $25.00 fee for failure to provide such notice. Furthermore, I understand that third party payers do not cover this cost.

Whom may we thank for referring you? _____

Name _____ Home Phone _____

Work Phone _____ Cell Phone _____

Address _____ Zip Code _____

City_____ State _____ Email_____

Age_____ Date of Birth _____ Height_____ Weight_____

Marital Status M W S D Number of Children _____

Social Security Number _____Drivers License Number _____

Occupation _____ Employed By_____

Spouse Name _____Phone Number _____

Emergency Contact _____ Phone Number _____

Reason for Visit: _____

_____

*Signature states understanding of all written policy of Angelo Chiropractic and Acupuncture Center.*

Name: _____ Signature: _____

Spouse/Guardian Signature: _____ Date: _____

Please be courteous and silence/turn off cell phones. We ask that you please arrive promptly to your appointment, all arrivals 10 minutes after appointment time will be rescheduled. Thank You!

# Acupuncture Questionnaire

Name: _____ Date: _____

Primary Care Physician: _____

Physician's Phone Number: _____

Instructions: Fill out this form by circling or checking the boxes that apply to you at least 80% of the time. Do this quickly without thinking about it too much. Be nonjudgmental with your answers. Leave blank any boxes that do not apply to you or of which you are uncertain. There are no correct answers. Your honesty will result in a better treatment.

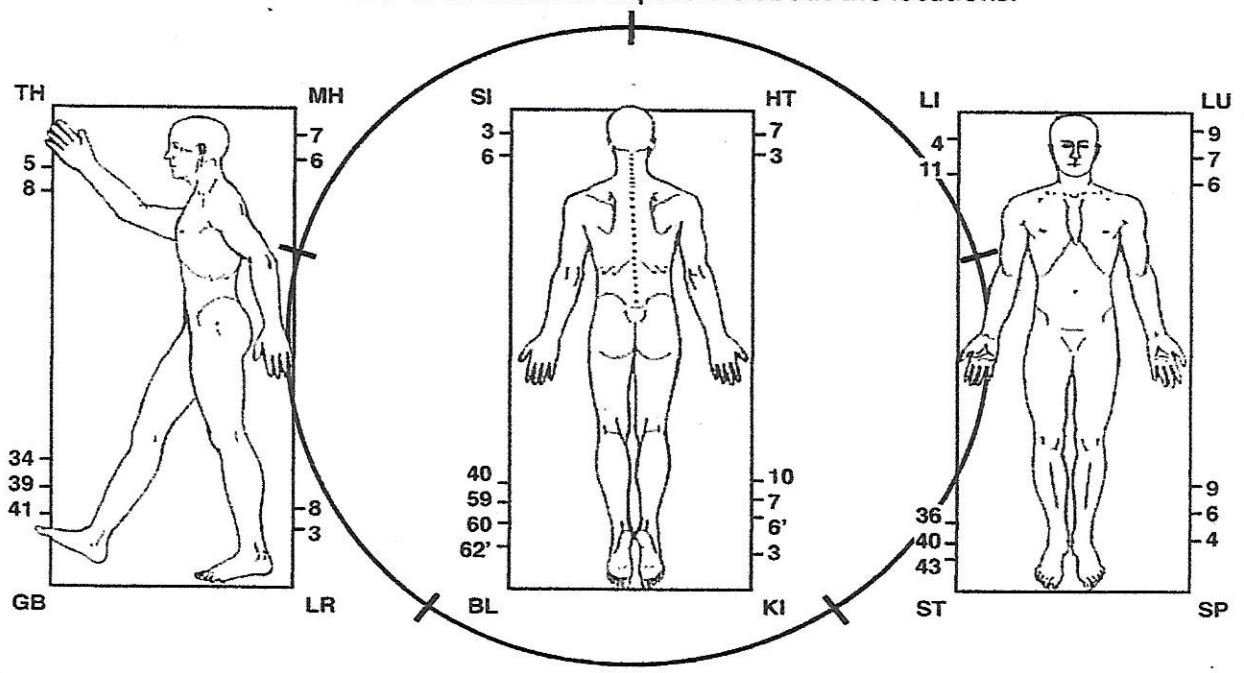
1. Start by listing in order of importance (1 being the most important) the reasons you wish to see the doctor.

| |
|---|
| 1. |
| 2. |
| 3. |
| 4. |

2. Please circle one answer for each of the following questions

| Five Phase Questions | Wood | Fire | Water | Earth | Metal |
|---|---|---|---|---|---|
| My favorite season | Spring | Summer | Winter | Harvest (late summer) | Autumn |
| My favorite color | Blue – Green (turquoise) | Red | Dark Blue or Black | Yellow (earth tones) | White |
| My favorite flavor | Sour, citrus, acidic | Bitter, roasted | Salty | Sweetness | Spicy, flavorful |
| My predominant emotional tendency | I tend to get angry. | I am excitable. | I get scared. | I tend to worry. | I tend to feel sad |
| My predominant psychological characteristic | I tend to be anxious and irritable. | I am joyful and creative. | I am willful and ambitious. | I often find myself in deep thought. | I tend to ger depressed |
| My usual reaction to stress | I clench, my muscles get | I tend to cry. | I tremble, my body feels shaky. | My stomach feels upset. | My chest feels tight |
| My fingernails can be characterized as | Elongated | Long and narrow | Crescent moon | Triangular | Rectangular |

3. On the anatomical figures below mark the area or areas where you have pain or other problems. Please be as accurate as possible about the locations.




**JUE YIN / SHAO YANG** **SHAO YIN / TAI YANG** **TAI YIN / YANG MING**

| Pain Assessment | Pain Assessment | Pain Assessment |
|---|---|---|
| Location: | Location: | Location: |
| Onset: | Onset: | Onset: |
| Makes Better:<br><br>Makes Worse: | Makes Better:<br><br>Makes Worse: | Makes Better:<br><br>Makes Worse: |
| Associated Symptoms: | Associated Symptoms: | Associated Symptoms: |
| Quality:<br>__ Constant __ Intermittent<br>__ Sharp __ Dull<br>__ Pressure __Burning | Quality:<br>__ Constant __ Intermittent<br>__ Sharp __ Dull<br>__ Pressure __Burning | Quality:<br>__ Constant __ Intermittent<br>__ Sharp __ Dull<br>__ Pressure __Burning |
| Severity:<br>1 2 3 4 5 6 7 8 9 10 | Severity:<br>1 2 3 4 5 6 7 8 9 10 | Severity:<br>1 2 3 4 5 6 7 8 9 10 |

Treatments I've tried: __ Physical Therapy __ Chiropractic __ Injections __ Other - Please Explain: ___