Date: _____ SSN: _____

First Name: _____ Last Name: _____

Sex: M / F / T Date of Birth: _____ Occupation: _____

Cell Phone: _____ E-Mail: _____

Alternate Phone: _____, _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us? Google, Yelp, Sustain Website, YouTube, Other _____

Who referred you? _____

Have you had acupuncture before: Y/N When? _____ With Whom: _____

Relationship Status: _____ No. Children: _____

(INT_____) 24 Hour Cancelation Policy: We have a 24-hour cancelation policy. Cancelations are only accepted via phone call or through the online scheduling software. **Appointments may not be made, changed or canceled via e-mail.** Late cancelations and no shows will be automatically charged. In cases of personal emergency, late charges may be applied to another appointment scheduled within 72 hours of the missed appointment.

(INT_____) Health Bundles: Some patients, who need to come in regularly, choose to purchase treatment bundles at a discount. These bundles have a set expiration date but can be extended for 30 days in special cases. Expired treatments or refunds are issued at a prorated price. For example if you used 6 visits of a 10 visit bundle, the 6 sessions would be counted at their full cash value and the difference refunded on account or as a check.

(INT_____) Health Insurance: Sustain is in most major insurance networks, and while your provider may indicate you have insurance benefits, it is not a guarantee they will pay for the visits. Patients are financially responsible for any services or portion of service not covered by their provider. **A valid credit card must be kept on file to cover unpaid expenses.**

(INT_____) Insurance Refunds: Patients who have paid the Time of Service (Cash) fees for their visits are entitled to a refund upon payment by the insurance company. Refunds will automatically be processed as an account credit. These credits can be used for a future co-pay or refunded as a check upon receipt of the **Explanation of Benefits** from your insurance provider.

(INT_____) I have read and agree to the **welcome letter and agree with the HIPPA agreement.** I understand that I will be treated in a community setting where my privacy will be respected, and I will respect the privacy of others.

X (Please sign): _____

Legal Guardian or Parent (Please sign): _____

I request the following restrictions to the use of disclosure of my health information:

_____

_____

_____

Patient name: _____ Height: _____ Weight: _____ BP: _____/_____

Allergies: _____

Medications: _____

Please describe your primary problem: _____

Are there any other health issues you are currently suffering from? (List up to 5)

1. _____
2. _____
3. _____
4. _____
5. _____

Are you currently under the care of a physician: **Yes / No** Past Surgeries: **Yes / No**
What treatments have you received in the past for these conditions?

☐ Surgery ☐Medication ☐Physical Therapy ☐Injections ☐Chiropractic ☐Massage

☐Other: _____

Please describe your progress: ☐ Worse ☐ No change ☐25% ☐50% or ☐75% Better

Are you taking Coumadin/Warfarin: ☐ Yes, ☐ No. Do you have a pacemaker: ☐ Yes, ☐ No.

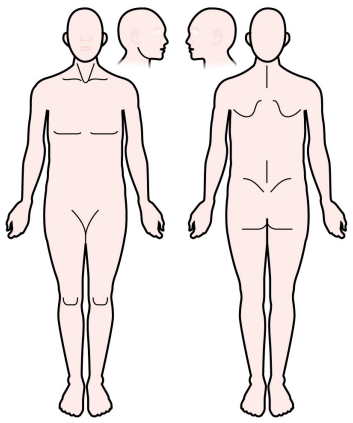
How much has the condition/pain interfered in your daily activities?

No interference – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Unbearable to carry on activities

How & When did it begin: _____

How often are the symptoms present? ☐Constant ☐Frequent ☐Intermittent ☐Occasional

Describe your current over all health: ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor



Check where you currently have pain:

☐Head ☐Neck ☐Jaw ☐Shoulder ☐Arm ☐Elbow

☐Wrist ☐Hand ☐Upper Back ☐Lower Back ☐Tailbone

☐Hip ☐Thigh ☐Knee ☐Ankle ☐Foot ☐Chest

☐Abdomen

Other: _____

_____

_____

_____

No Pain 1–2–3–4–5–6–7–8–9–10 Unbearable

Please List Your Health Goals: _____

_____

What has kept you from being healthy in the past: _____

Patients who are coachable and who can take action to change their lifestyle benefit best from working with an Acupuncturist. Can you make minor changes to Sleep, Diet Exercise and do Stress Management Exercises if it will improve your condition faster? **Yes / No**

If Sustain can help you accomplish your goals, in an affordable time conscious way, is there anything else that could prevent you from getting started today? **Yes / No**

Please List any Reasons: _____

Please mark all that apply. **Mark with a slash (/) if you *sometimes* experience the symptom; mark with an "x" if you *frequently* experience it.**

Digestion: ☐ poor appetite ☐ excessive hunger ☐ nausea/vomiting ☐ acid regurgitation/heartburn ☐ abdominal pain ☐ constipation (<1x/day) ☐ loose stools or diarrhea ☐ foul smelling stool ☐ pale stool ☐ dark, tarry stool ☐ bloating ☐ unexplained weight loss/gain ☐ excess flatulence ☐ unexplained weight loss/gain ☐ sweet/sour/bitter taste in mouth ☐ thirst w/o desire to drink ☐ excessive thirst ☐ preference for warm water ☐ preference for cold water ☐ food cravings/what kind?_____ glasses of water per day _____	**Reproductive** ☐ low libido ☐ excessive libido ☐ pain during sex **Women only** ☐ age at first menses _____ # of days in cycle _____ # of days with period _____ # heavy ____ med ____ light _____ # pregnancies ____ Live births ___ ☐ large clots in flow ☐ vaginal discharge **premenstrual symptoms:** ☐ digestive changes_____ ☐ mood changes_____ ☐ pain _____ ☐ breast tenderness **Men only** ☐ cold or numbness in genitals ☐ premature ejaculation ☐ swollen or painful testes ☐ erectile disorders	**Cardiovascular:** ☐ heart palpitations ☐ chest pressure ☐ tachycardia/bradycardia ☐ arrhythmia ☐ circulatory issues ☐ varicose veins ☐ edema ☐ dizziness ☐ cold hands/feet ☐ cold fingers/toes **Urination/Sweat:** ☐ Frequent urination ☐ scant or dribbling urination ☐ dark/cloudy or bloody urination ☐ pain on urination ☐ urinary incontinence ☐ kidney stones ☐ bladder infections ☐ urinary tract infections ☐ profuse sweating ☐ no sweat ☐ night sweats ☐ sweaty palms
Respiratory: ☐ cough ☐ wheeze/asthma ☐ allergies ☐ shortness of breath ☐ chest pressure ☐ sore throat ☐ fatigue ☐ hoarse voice ☐ frequent colds (>1 per yr) ☐aversion to ☐ wind ☐ heat ☐ cold ☐ hot flashes ☐ feelings of warmth ☐ evening fever ☐ alternating fever/chills ☐ tendency to feel cold ☐ cold hands/feet	**Mood/Sleep/Energy** ☐ depression ☐ anxiety ☐ frequent irritability ☐ easily startled ☐ easily irritated or angered ☐ vivid dreams ☐ nightmares ☐ difficulty falling asleep ☐ waking in night ☐ restless sleep sensitive to stress ☐ mental fogginess ☐ worry; over-thinking ☐ fatigue; Worse or better after exercise? _____ ☐ muscle weakness ☐ muscle cramping	**HEENT** ☐ dry or gritty eyes ☐ red or itchy eyes ☐ visual floaters ☐ near- or far- sightedness ☐ excessive tearing ☐ dry hair or skin ☐ nosebleeds ☐ snoring ☐ hair loss ☐ acne ☐ ringing in ears ☐ headaches ☐ vertigo ☐ rashes ☐ skin irritation ☐ eczema
Medical History ☐ cancer ☐ diabetes ☐ hepatitis ☐ heart disease ☐ hypertension ☐ low blood pressure ☐ thyroid disorders ☐ seizures ☐ arthritis ☐ psychological disorders ☐ tuberculosis ☐ sexually transmitted infections (list) _____	**Drug/alcohol use** ☐ # of alcoholic drinks per week ___ ☐ recreational drugs_____ ☐ history of smoking # cigarettes per day _____ # of years smoking _____ ☐ currently smoking/quit date _____ ☐ coffee / tea: # cups per day ____	**Other:**